

SERIES 4

# UNICARE STATE INDEMNITY PLAN/PLUS

Member Handbook for Active Employees and  
Non-Medicare-Eligible Retirees

Effective July 1, 2009



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|                            |                        |                                 |
|----------------------------|------------------------|---------------------------------|
| <b>UniCare State</b>       | <b>Express Scripts</b> | <b>United Behavioral Health</b> |
| <b>Indemnity Plan/PLUS</b> | (877) 828-9744         | (888) 610-9039                  |
| (800) 442-9300             | TDD: (800) 842-5754    | TDD: (800) 842-9489             |
| TDD: (800) 322-9161        |                        |                                 |

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.





# Welcome to the UniCare State Indemnity Plan/PLUS

This Handbook is a guide to benefits for you and your covered dependent(s) under the UniCare State Indemnity Plan/PLUS (the PLUS Plan). These benefits are provided through the Group Insurance Commission (GIC), the state agency responsible for the design and payment of all benefits for people insured through the GIC. This Plan is funded by the Commonwealth of Massachusetts and administered by UniCare.

UniCare provides administrative services for the UniCare State Indemnity Plan/PLUS such as claims processing, customer service, utilization management and medical case management at its Andover Service Center in Andover, Massachusetts. UniCare is not the fiduciary or the insurer of the PLUS Plan.

Throughout this Handbook, the UniCare State Indemnity Plan/PLUS is referred to either by its full name, as the “PLUS Plan” or as the “Plan.” The Group Insurance Commission is referred to by its full name or as the “GIC.”

**To fully understand your benefits, please read this Handbook carefully.**

## How This Handbook Is Organized

Descriptions of the benefits available to you and your covered dependent(s) are provided in the following three parts of this Handbook.

### Part 1: Medical Benefits

This part of the Handbook describes the benefits available under the PLUS Plan for medical services, treatment and supplies. These benefits are administered by **UniCare**. See page 1.

### Part 2: Prescription Drug Plan

This part of the Handbook describes the prescription drug benefits, which are administered by **Express Scripts**. See page 69.

### Part 3: Mental Health, Substance Abuse and Employee Assistance Programs

This part of the Handbook describes the mental health, substance abuse and Employee Assistance Programs of the PLUS Plan, which are administered by **United Behavioral Health (UBH)**. See page 79.

If you have questions about any of your benefits, please refer to the contact information on page 5.

## About Your Medical Plan

The PLUS Plan provides comprehensive coverage for many health services including hospital stays, surgery, emergency care, preventive care, outpatient services and other medically necessary treatment. It is important to keep in mind that benefits differ depending on the provider and/or the service and that not all services are covered under the Plan.

### Physician Services

As a PLUS member, you can see any Massachusetts physician. You will pay lower office visit copays when you use Tier 1 and Tier 2 physicians in Massachusetts. You are not required to choose a primary care physician and you do not need a referral to see a specialist.

PLUS members who live in Connecticut, Maine, New Hampshire or Rhode Island also have access to PLUS physicians in their state at the same benefit level as with Massachusetts physicians. When you use these physicians you pay a Tier 2 level copay.

### Hospital Services



With the PLUS Plan, there are different deductibles for inpatient and outpatient hospital care. You have a lower hospital deductible when you use Massachusetts acute care hospitals that are designated as Tier 1 or Tier 2. You pay a higher deductible for care received at Massachusetts acute care hospitals designated as Tier 3.


PLUS members who live in Connecticut, Maine, New Hampshire or Rhode Island also have access to PLUS hospitals in their state at the same benefit level as with Massachusetts hospitals. When you use these hospitals, you pay a Tier 2 level inpatient hospital deductible and a Tier 2 level outpatient surgery deductible.

PLUS providers consist of all Massachusetts providers (except for non-Preferred Vendors), and non-Massachusetts providers in the UniCare provider network. Non-PLUS providers are providers outside Massachusetts that are not part of the UniCare provider network.


## How to Receive the Highest Level of Benefits from Your Medical Plan


Please read the following information carefully to ensure that you receive the maximum level of Plan benefits for medically necessary services.

- **In Massachusetts:** You'll save on out-of-pocket costs for physician office visits and hospital care when you use Tier 1 or Tier 2 physicians and hospitals in Massachusetts.  For more information on physician tiering, see page 12 in the Your Costs section of this Handbook, or visit [www.unicarestateplan.com](http://www.unicarestateplan.com) and click on "Forms and Documents" under the "Members" tab.
  - **Massachusetts Physicians:**  To find out which tier your physician is in, log onto the Plan's web site: [www.unicarestateplan.com](http://www.unicarestateplan.com). Click on "Physician Tier Listing" under "Find a Provider." You can also check the printed Provider Listing, or call the Andover Service Center at (800) 442-9300 for assistance.
  - **Massachusetts Hospitals:** To find out the tier designation for a Massachusetts acute care hospital, see Appendix C: Tier Designations for Massachusetts Acute Care Hospitals at the back of this Handbook.
- **For Residents of Connecticut, Maine, New Hampshire and Rhode Island:** PLUS members living in these states also have access to PLUS

providers in their state. When you use these providers, you receive the same coverage as you would with Massachusetts providers. You will pay the Tier 2 level copay for physician office visits, the Tier 2 level outpatient surgery deductible, and the Tier 2 level inpatient deductible for hospital care in these states.  To locate PLUS providers in Connecticut, Maine, New Hampshire or Rhode Island, log onto [www.unicarestateplan.com](http://www.unicarestateplan.com). Click on "out-of-state network providers" under "Find a Provider" and follow the directions, or call UniCare Customer Service at (800) 442-9300 for assistance.

- **When You Travel:** When you travel outside your home state, you have access to UniCare's Travel Access providers for urgent care—except for mental health and substance abuse providers. Our Travel Access providers agree not to balance bill you for charges above the Plan's allowed amount. Student dependents who attend school full time in states other than Massachusetts also have access to UniCare's Travel Access providers. It is important for you and your dependent(s) to use these providers while outside Massachusetts so you won't be balance billed for care you receive.


 To locate a Travel Access provider when you travel, log onto [www.unicarestateplan.com](http://www.unicarestateplan.com). Click on "out-of-state network providers" under "Find a Provider" and follow the directions. Or call UniCare Customer Service at (800) 442-9300 for assistance.

- The Andover Service Center must be notified at (800) 442-9300 for **all hospital admissions** and for certain selected outpatient procedures and services. The **telephone symbol**  you see throughout this Handbook lets you know that, to obtain the maximum level of benefits, you or your provider must call the Andover Service Center within the specified time frame. Failure to do so will result in a reduction in benefits of up to \$500. However, you do not need to call the Plan if you are outside the continental United States (the contiguous 48 states). Please refer to the Managed Care section of this Handbook for specific notification

requirements and responsibilities. You'll also find details regarding what information you need to provide when you call the Plan to give notification of an admission or service.

- To enhance your level of benefits, you can also use the Plan's Preferred Vendors for the following services:


- durable medical equipment
- medical/diabetic supplies
- home health care
- home infusion therapy

 For a list of the Plan's Preferred Vendors, log onto the Plan's web site: [www.unicarestategroup.com](http://www.unicarestategroup.com). Select the link for "All Provider Listings" and then the link for "Preferred Vendors," or call the Andover Service Center at (800) 442-9300.

- Carry your UniCare State Indemnity Plan ID card with you at all times and always show it when you go for care. This enables your provider to confirm your eligibility for Plan benefits.

## Online Access to Medical Information and Plan Resources at [www.unicarestategroup.com](http://www.unicarestategroup.com)

For your convenience, you can access a broad range of Plan-related and general health care information, as well as helpful tools on the Plan's web site: [www.unicarestategroup.com](http://www.unicarestategroup.com).


The **computer symbol**  that you see throughout this Handbook indicates that information on the highlighted topic is available on the Plan's web site: [www.unicarestategroup.com](http://www.unicarestategroup.com).

Our comprehensive web resources give you the ability to:

- **Manage and improve your health with tools and information provided through Healthy Living, powered by WebMD®.** It includes health assessments, links to health articles, product alerts and recalls. This resource also offers interactive online programs allowing you to access items such as tracking tools for your diet, fitness, weight management and medication needs.
- **Get help from the Healthcare Advisor<sup>SM</sup>** with making reliable decisions about physicians, hospitals and treatments so you can confidently manage your health care. The Healthcare Advisor provides extensive health care information designed to help Plan members understand and manage various health conditions, treatments and procedures. This resource also provides profiles of health care facilities to help members assess where to best receive care, based on their needs and preferences.
- **Locate providers**, including UniCare out-of-state network providers and Preferred Vendors. You can also check our Physician Tier Listing to see which tier your physician is in.
- Get convenient, secure access to **information about your claims**.
- Check out the Plan's **discounts on health-related products and services** available through the HealthyExtensions<sup>SM</sup> Program.
- **E-mail the Plan or order Plan materials**, such as ID cards and Member Handbooks.
- **View Plan documents**, including your Member Handbook, any Benefit Updates to your Handbook and other Plan information.

## MedCall 24/7 Nurse Information Line

The PLUS Plan's MedCall® 24/7 Nurse Information Line provides around-the-clock, toll-free access to registered nurses who can answer your questions about procedures or symptoms that you would like to discuss. Nurses can provide information about appropriate care settings and help you prepare for a doctor's visit. They can also discuss your medications and any potential side effects. MedCall also serves as a referral source for local, state and national self-help agencies. To speak with a nurse, call MedCall toll-free at (800) 424-8814. You will need to provide the following Plan-specific code: 1002.

By calling the above number, you can also access MedCall's library of more than 300 audio tapes to get automated information over the phone on many health-related topics.  To view the list of available audio tapes, log onto [www.unicarestategroup.com](http://www.unicarestategroup.com).




## Important Plan Information

### Overview

This section gives you important information about the PLUS Plan, including:


- the Andover Service Center and how its staff can help you
- the process for ordering new identification cards when needed
- how to access a language interpreter when speaking with a customer service representative at the Andover Service Center
- contact information when you have questions about your medical plan, your prescription drug plan or your mental health, substance abuse and Employee Assistance Programs
- the Plan's Notice of Privacy Practices

### The Andover Service Center

The Andover Service Center is where UniCare administers services; processes claims; and provides customer service, utilization management and medical case management for the medical component of the PLUS Plan. Representatives are available at (800) 442-9300 Monday through Thursday from 7:30 a.m. to 6:00 p.m. and Friday from 7:30 a.m. to 5:00 p.m. to answer questions you and your dependent(s) may have about your medical coverage. You can also access claims information 24 hours a day, seven days a week from our automated telephone line, or from the Plan's web site: [www.unicarestateplan.com](http://www.unicarestateplan.com). 

When you call the Andover Service Center, you will speak with customer service representatives or patient advocates, depending on the nature of your call.

**Customer service representatives** are benefits specialists who can answer questions about:


- claim status
- notification requirements
- covered services
- PLUS providers
- Plan benefits
- resources on the Plan's web site: [www.unicarestateplan.com](http://www.unicarestateplan.com) 

**Patient advocates** are registered nurses who can help you coordinate your health care needs with the benefits available under the Plan. A patient advocate can:

- provide information about the Managed Care Program, including Utilization Management, Medical Case Management, and Quality Centers and Designated Hospitals for Transplants
- answer questions about the Plan's coverage for hospital stays and certain outpatient benefits
- speak with you and your physician about covered and non-covered services to help you obtain care and coverage in the most appropriate health care setting and let you know what services are covered, and
- assist you with optimizing benefits for covered services after you are discharged from the hospital

### Your Identification Card

When you are enrolled in the PLUS Plan, you will receive an identification (ID) card. Be sure to present your ID card when you seek medical care. Your card contains useful information about your benefits and important telephone numbers you and your doctor may need.

 If you lose your ID card or need additional cards, you can order new cards from the Plan's web site at [www.unicarestateplan.com](http://www.unicarestateplan.com). You can also call the Andover Service Center at (800) 442-9300.

## Important Plan Information

### Interpreting and Translating Services

If you need a language interpreter when you contact the Andover Service Center, a customer service representative will access a language line and connect you with an interpreter who will translate your conversation with the representative.

If you are deaf or hard of hearing and have a TDD machine, you can contact the UniCare State Indemnity Plan/PLUS by calling its telecommunications device for the deaf (TDD) line at (800) 322-9161 or (978) 474-5163.

### Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. The GIC keeps the health and financial information of current and former members private, as required by law. This notice also explains your rights as well as the GIC's legal duties and privacy practices. The GIC's policies comply with the Health Insurance Portability and Accountability Act (HIPAA), which was signed into federal law in August 1996 to help improve the efficiency of the health care system in the United States.

The GIC's Notice of Privacy Practices is contained in Appendix A at the back of this Handbook. Please read this notice carefully.

### Important Contact Information

If you have questions, please contact the following:

*For information about your medical benefits:*

#### **UniCare State Indemnity Plan/PLUS**

P.O. Box 9016

Andover, MA 01810-0916

(800) 442-9300

TDD: (800) 322-9161

[www.unicarestatplan.com](http://www.unicarestatplan.com)

*For information about your prescription drug plan:*

#### **Express Scripts**

(877) 828-9744 (toll free)

TDD: (800) 842-5754

[www.express-scripts.com](http://www.express-scripts.com)

*For information about your mental health and substance abuse benefits and Employee Assistance Program:*

#### **United Behavioral Health**

(888) 610-9039 (toll free)

TDD: (800) 842-9489

[www.liveandworkwell.com](http://www.liveandworkwell.com)

(access code: 10910)

### Overview

This section describes the costs that you may be responsible for paying in connection with services covered by the Plan. These costs include copayments, deductibles and coinsurance. This section also explains how the Plan reimburses health care providers, and provides information regarding physician tiering and the use of non-Massachusetts providers.

### Deductibles

A deductible is a fixed dollar amount you pay for certain services before the Plan begins paying benefits for you or your covered dependent(s). The deductible amounts you must satisfy are shown in the chart on page 7.

#### Individual Calendar Year Deductible

The individual calendar year deductible is the amount you must pay before benefits for many services begin for that calendar year. In the PLUS Plan, you only have an individual calendar year deductible when you use non-PLUS providers or non-Preferred Vendors. Non-PLUS providers are providers outside Massachusetts that are not part of the UniCare provider network. PLUS providers consist of all Massachusetts providers (except for non-Preferred Vendors), and non-Massachusetts providers in the UniCare provider network.

**For example:** If you go to a **non-PLUS** provider for a medical problem in January, you will have to pay the office visit copay and then \$100 of the allowed amount. If your provider charges less than \$100, the balance of the deductible will be taken from your next visit. If there are remaining charges after the deductible, then the Plan pays 80% of the Allowed Amount and you will be responsible for the remaining 20%. Once you have paid the \$100 calendar year deductible, you will not have to pay it again for the remainder of the year, regardless of the types of services you receive.

The Plan determines the providers to whom you owe the deductible based on the order the claims are submitted. You will receive an Explanation of Benefits (EOB) that will indicate the provider(s) to whom you owe deductible amounts for any services you receive from non-PLUS providers.

Some of the types of charges the calendar year deductible applies to are office visits and outpatient hospital services. The calendar year deductible does not apply to preventive care visits and x-rays, or to any service provided by a Massachusetts provider, a Preferred Vendor or a UniCare out-of-state network provider. Check the Benefit Highlights section to see where the calendar year deductible is applied.

#### Family Calendar Year Deductible

If you have family coverage and use non-PLUS providers, a deductible will apply to your family in any calendar year. There is no family calendar year deductible when you use PLUS providers.

**For example:** You, your spouse and your three children have family coverage under the PLUS Plan. You and two of your children go to non-PLUS providers for medical care in January. Two of you pay \$75 deductibles and one of you pays a \$50 deductible. Even though no one in the family has met the \$100 individual deductible, because the family deductible of \$200 has been met, no additional calendar year deductible will apply to your family.

#### Deductible Carryover

Any amounts you pay toward the individual calendar year deductible in the last three months of a calendar year will be applied toward the deductible for the next calendar year. Carryover does not apply to the inpatient hospital quarterly deductible.

## Your Costs

| Deductibles  | When You Use a PLUS Provider  | When You Use a Non-PLUS Provider  |
|--|---|---|
| Individual Calendar Year Deductible  | None  | \$100   |
| Family Calendar Year Deductible  | None  | \$200   |
| Inpatient Hospital Quarterly Deductible <sup>1</sup>   | Tier 1: \$250 <sup>2</sup><br>Tier 2: \$500 <sup>2</sup><br>Tier 3: \$750 <sup>2</sup>  | \$500   |
| Select Complex Inpatient Procedures and High-Risk Deliveries and Neonatal ICUs at a Designated Hospital <sup>3</sup> | \$250 (when you use a designated PLUS Tier 2 or Tier 3 hospital)  | \$500   |
| Quality Centers and Designated Hospitals for Transplants <sup>4</sup>  | \$250 (when you use a Massachusetts hospital that is a Quality Center or Designated Hospital for Transplants <sup>4</sup> )<br><br>\$500 (when you use a Massachusetts Tier 2 hospital that is not a Quality Center or Designated Hospital for Transplants <sup>4</sup> )<br><br>\$750 (when you use a Massachusetts Tier 3 hospital that is not a Quality Center or Designated Hospital for Transplants <sup>4</sup> ) | \$250 (when you use a Quality Center or Designated Hospital for Transplants <sup>4</sup> )<br><br>\$500 (when you use a hospital that is not a Quality Center or Designated Hospital for Transplants <sup>4</sup> ) |
| Outpatient Surgery Quarterly Deductible  | Tier 1: \$100 <sup>2</sup><br>Tier 2: \$100 <sup>2</sup><br>Tier 3: \$250 <sup>2</sup>  | \$100   |

<sup>1</sup> The inpatient hospital quarterly deductible is waived for readmissions that occur within 30 days following a hospital discharge, within the same calendar year.

<sup>2</sup> To find out a hospital's tier designation, see Appendix C at the back of this Handbook.

<sup>3</sup> For a list of these procedures and hospitals, see Appendix D at the back of this Handbook.

<sup>4</sup> To find Quality Centers and Designated Hospitals for Transplants, please call the Andover Service Center at (800) 442-9300 and ask to speak with a case manager.

### Inpatient Hospital Quarterly Deductible

The inpatient hospital quarterly deductible applies on a per-person, per-calendar year quarter basis. Each time you or a covered dependent is admitted to a hospital, you are responsible for this deductible. However, once a covered person satisfies this deductible in any single calendar year quarter, he or she will not have to satisfy the deductible again during that same calendar year quarter. In addition, the inpatient hospital deductible is waived for readmissions that occur within 30 days following a hospital discharge within the same calendar year (even if the admissions occur in different calendar year quarters). This deductible does not apply toward the calendar year deductible.

**Example 1:** If you are admitted to a hospital in January and stay overnight, you will be responsible for paying the inpatient hospital deductible. If you are readmitted to a hospital in March, you will not be responsible for another inpatient hospital deductible, as March is in the same calendar quarter as January. However, if you are readmitted to a hospital in May, you will incur another deductible.

**Example 2:** If you are admitted to a hospital at the end of March and then readmitted in April (within 30 days of your March discharge), you will not be responsible for another inpatient hospital deductible. But if you are readmitted to a hospital in May (more than 30 days from your March discharge), you will incur another deductible.

**Example 3:** If you are admitted to a hospital at the end of December and then are readmitted in the beginning of January, you will be responsible for another inpatient hospital deductible because the admissions were not in the same calendar year (even though the two admissions occur within 30 days of each other).

### Outpatient Surgery Quarterly Deductible

The outpatient surgery quarterly deductible is a per-person, per-calendar year quarter deductible. Each time you or a covered dependent has surgery at a hospital, you are responsible for paying this

deductible. However, once a covered person satisfies the outpatient surgery quarterly deductible in any calendar year quarter, he or she will not have to satisfy this deductible again during that same calendar year quarter. This deductible does not apply toward the calendar year deductible. (Note: When you have outpatient surgery at a freestanding ambulatory surgical facility or at a physician's office, you do not have to pay the outpatient surgery quarterly deductible.)

**For example:** If you have outpatient surgery at a hospital in January, you will be responsible for paying the outpatient surgery deductible on the hospital charges. If you have another surgery in March, you will not have to pay another outpatient surgery deductible as March is in the same calendar year quarter as January. However, if you have surgery at a hospital in May, you will incur another outpatient surgery deductible.

### Copayments

A copayment ("copay") is a fixed dollar amount you pay to a provider at the time of service. Copay amounts vary depending on the provider, the type of service you receive and the tier level of the physician. Copays are always deducted before the individual calendar year deductible is applied (where applicable). Copays do not count toward satisfying deductibles, coinsurance amounts or out-of-pocket maximums.

**Example 1:** If you are a member of the PLUS Plan and you or a covered dependent go to a physician's or chiropractor's office, you or your dependent will be responsible for paying an office visit copay.

Although you usually pay the copay at the time of the visit, you can also wait until the provider bills you.

**Example 2:** You may owe an emergency room copay every time you go to the emergency room. This copay is waived if you are admitted to the hospital. However, if you are admitted to the hospital, the inpatient hospital quarterly deductible applies.



## Your Costs

### Copays for Medical Services

The chart below shows the copays you are responsible for with certain types of medical services. The names of the tiers have been assigned by the GIC for use uniformly across all of its health plans. For information about physician tier designations, see page 12. (Please note that you are not required to select a primary care physician.)

| Type of Medical Visit  | Copay<br>(when you use a PLUS provider)   | Copay<br>(when you use a non-PLUS provider) |
|--|---|---|
| Emergency Room Visit   | \$75 (waived if admitted)   | \$75 (waived if admitted)                   |
| Physician Office Visits  | <b>Tier 1*** (excellent):</b> <ul style="list-style-type: none"> <li>Primary care physicians:<sup>1</sup> \$10</li> <li>Specialty care physicians: \$20</li> </ul> <b>Tier 2** (good):</b> <ul style="list-style-type: none"> <li>Primary care physicians:<sup>1</sup> \$25</li> <li>Specialty care physicians: \$25</li> </ul> <b>Tier 3* (standard):</b> <ul style="list-style-type: none"> <li>Primary care physicians:<sup>1</sup> \$30</li> <li>Specialty care physicians: \$40</li> </ul> | \$25  |
| Services Provided by Nurse Practitioners   | \$25  | \$25  |
| Licensed Retail Medical Clinics at Pharmacies  | \$15  | \$15  |
| Physical Therapy and Occupational Therapy  | \$15  | \$15  |
| Chiropractic Care  | \$15  | \$15  |
| Outpatient High-Tech Imaging (such as MRIs, CT scans and PET scans) at Hospital and Non-Hospital Locations | \$75 per scan; maximum of one copay per day   | \$75 per scan; maximum of one copay per day |
| Routine Eye Examinations:<br>With an Optometrist<br>With an Ophthalmologist                                | \$25<br>See office visit copays for specialty care physicians above   | \$25<br>\$25                                |

<sup>1</sup> Primary care physicians are pediatricians, and physicians specializing in family medicine, general medicine and/or internal medicine. Some primary care physicians may also be specialty care physicians and, if so, may be considered to be specialists in the determination of their tier and copay assignments. This means you will pay the office visit copay for the type of practice the physician has been designated to, regardless of whether you see the physician for a primary care or specialty care visit.

You can also see the following providers at the Tier 2 level copay:

- All non-Massachusetts physicians
- Massachusetts physicians not included in the Provider Listing
- Physicians included in the Provider Listing with the indication that they do not have sufficient data available to allow us to determine any type of scoring—such as those physicians who are new to practice. These physicians are identified in this Listing as Not Tiered/Insufficient Data (NT/ID).
- Physician assistants

### Coinsurance

Coinsurance is the percentage of the allowed amount that you must pay for covered services after any applicable copay or deductible is satisfied. For example, if the Plan pays 80% of the allowed amount for certain services, you are responsible for paying the remaining 20%. To see which benefits coinsurance applies to, refer to the Benefit Highlights section. In addition, you may be responsible for the difference between the allowed amount and the provider's charge for services received from providers outside of Massachusetts if you do not use PLUS providers or UniCare Travel Access providers.

### Out-of-pocket Maximum

To protect you from large medical expenses, the Plan limits the amount of coinsurance you pay out-of-pocket each year for certain covered services. This out-of-pocket maximum applies to each covered person, as follows:

| PLUS Provider | Non-PLUS Provider |
|---------------|-------------------|
| \$750         | \$3,000           |

Once you reach the out-of-pocket limit, the Plan pays 100% of the allowed amount for the designated covered services for the rest of the calendar year.

The following out-of-pocket expenses do not apply toward your out-of-pocket maximum:

- Deductibles
- Copayments
- Certain coinsurance amounts (to find out which coinsurance amounts do not apply toward the out-of-pocket maximum, see the Benefit Highlights section)
- Amounts in excess of the Plan's allowed amounts (balance billing)
- Amounts for non-covered services

If you are using PLUS providers, the only medical costs that apply toward the out-of-pocket maximum are home health care, prostheses, braces and other covered medical services such as allergy serum. PLUS providers consist of all Massachusetts providers (except for non-Preferred Vendors), and non-Massachusetts providers in the UniCare provider network. Non-PLUS providers are providers outside Massachusetts that are not part of the UniCare provider network.

### Reasonable and Customary Charge

Charges for covered services are reasonable and customary to the extent that they do not exceed the general level of charges for like or similar treatment, services or supplies by other providers in the area where the charges are incurred. Charges in excess of the Reasonable and Customary Charge are not considered for payment under the Plan.

### Reasonable and Customary Allowed Amount

The Reasonable and Customary Allowed Amount (also referred to as the allowed amount) is the amount UniCare determines to be within the range of payments most often made to similar providers for the same service or supply. These allowed amounts are expressed as maximum fees in fee schedules, maximum daily rates, flat amounts or discounts from charges.

The PLUS Plan has established Reasonable and Customary Allowed Amounts for most services from providers. This allowed amount may not be the same as the provider's actual charge.

### Charges over the Reasonable and Customary Allowed Amount

Whether located within or outside of Massachusetts, PLUS providers are required to accept the Plan's allowed amount. Therefore, they cannot balance bill you for any charges exceeding the allowed amount determined by the Plan. In some cases, a non-PLUS provider may bill you for charges over the allowed amount (balance billing). The Plan will not consider these charges for payment.


#### Massachusetts Providers

Under Massachusetts General Law, Chapter 32A: Section 20, providers who render services in Massachusetts are prohibited from billing you for the amount in excess of Plan determined or allowed amounts. If you receive a bill for charges above the allowed amount from a Massachusetts provider, contact the Andover Service Center at (800) 442-9300 to help you resolve this issue.


#### Non-Massachusetts Providers

Non-PLUS providers outside Massachusetts may balance bill you for the difference between the payments made by the Plan, based on the Plan's allowed amount and the full amount the provider charged. The charges in excess of the Plan's allowed amounts will not be considered for payment by the Plan.

- **For Residents of Connecticut, Maine, New Hampshire and Rhode Island:** PLUS members living in these states also have access to PLUS providers in their state at the same benefit level as when they use Massachusetts providers. If you receive a bill for charges above the allowed amount from a PLUS provider, contact the Andover Service Center at (800) 442-9300 to help you resolve this issue. When you use these

providers, please show your UniCare out-of-state ID card.  To locate PLUS providers in Connecticut, Maine, New Hampshire or Rhode Island, log onto [www.unicarestateplan.com](http://www.unicarestateplan.com). Click on "out-of-state network providers" under "Find a Provider" and follow the directions.

- **When You Travel:** When you travel outside your home state, you have access to UniCare's Travel Access providers for urgent care—except for mental health/substance abuse providers. Travel Access providers agree not to balance bill you for charges above the Plan's allowed amount. Student dependents who attend school full time in states other than Massachusetts also have access to UniCare's Travel Access providers. It is important for your dependent to use these providers while outside Massachusetts so you won't be balance billed for his or her care. When you use Travel Access providers, please show your UniCare State Indemnity Plan ID card.

 For a list of providers available to you when you are traveling outside of Massachusetts, please check the online provider finder at [www.unicarestateplan.com](http://www.unicarestateplan.com). Click on "out-of-state network providers" under "Find a Provider" and follow the directions. The provider finder will help you identify UniCare's Travel Access providers that will not balance bill you for your care.

**Important: If you need mental health/substance abuse treatment or the Employee Assistance Program (EAP), you must contact United Behavioral Health (UBH), the administrator for these services. You will be subject to balance billing if you use a mental health/substance abuse provider that is not in the UBH network. (For more information, see pages 79–94.)**

## Your Costs

### Provider Reimbursement

The PLUS Plan reimburses providers on a fee-for-service basis. The Plan does not withhold portions of benefit payments from providers, nor offer incentive payments to providers related to controlling the utilization of services. Explanations of provider payments are detailed in your Explanations of Benefits (EOBs). Under the Plan, providers are not prohibited from discussing the nature of their compensation with you.

### Physician Tiering


To help you make more informed choices about your health care options and to control your premium costs, the Group Insurance Commission's (GIC) Clinical Performance Improvement (CPI) Initiative includes a physician tiering program. Under this program, Massachusetts physicians are assigned to tiers based on an evaluation of various quality and cost-efficiency measures for physicians.

Based on a comparison of their scores with their peers in the same specialties on these efficiency measures, as well as whether the physician met certain quality benchmarks, individual physicians are assigned to one of three tiers, as described below. The names of the tiers have been assigned by the GIC for use uniformly across all of its participating health plans.

- **Tier 1<sup>\*\*\*</sup>** (Excellent) – Tier 1 physicians are those who met or exceeded the quality assessment threshold, established for all physicians, and ranked at the highest level of cost-efficiency, as compared to their peers. Tier 1 is designed to acknowledge the high performance of these physicians in terms of both quality and cost-efficiency measures, as determined by the available data.
- **Tier 2<sup>\*\*</sup>** (Good) – Tier 2 physicians are those who demonstrate good practice patterns. They have met or exceeded the quality assessment threshold established for all physicians and have met the cost-efficiency threshold established by the Plan, but did not achieve scores as high as Tier 1 physicians.


- **Tier 3<sup>\*</sup>** (Standard) – Tier 3 physicians are those who did not meet the quality threshold established for all physicians, or they did not meet the cost-efficiency threshold established by the Plan.

**Note:** For a variety of reasons, many physicians did not have sufficient data available during the data collection period to allow us to assess their quality and/or cost-efficiency. Some may lack sufficient data with regard to the quality measures and/or the cost-efficiency measures. These physicians are placed in the category of Not Tiered/Insufficient Data (NT/ID). You can see these physicians for a Tier 2 level copay.

 You will find detailed explanations about the assignment of doctors to tiers and about the methods used to determine the quality and cost-efficiency scores of the physicians at [www.unicarestateplan.com](http://www.unicarestateplan.com) under “Forms and Documents.” You can also call the Andover Service Center at (800) 442-9300 to request materials.

The methodology used in this tiering process relies on nationally accepted approaches to evaluating both quality and efficiency, and uses claims data submitted by health care providers themselves. The use of claims data has some limitations, and there are additional methods that you may wish to use in evaluating the quality and efficiency of providers. In making decisions about choosing your providers, you should consider the potential limitations in the data as well as other factors that correlate with the quality of care that you receive, some of which may be subjective in nature, but which are important to you.

### How to Find out Your Physician's Tier Designation

 To find out which tier your physician is in, log onto the Plan's web site: [www.unicarestateplan.com](http://www.unicarestateplan.com); under “Find a Provider” click on the link for the “Physician Tier Listing.” You can also check the printed Provider Listing, or call the Andover Service Center at (800) 442-9300 for assistance.

### Overview


This section provides information on how to submit a claim, how your benefits are covered when you have coverage under more than one health plan, how to view your claims online, your appeal rights under the Plan, and other important information relating to your claims.

### How to Submit a Claim

To receive benefits from the Plan, a claim must be filed for each service. Most hospitals, physicians or other health care providers will submit claims for you. If your provider files claims on your behalf, the provider will be paid directly. If you submit your own claim, you must include written proof of the claim that includes:

- diagnosis
- date of service
- amount of charge
- name, address and type of provider
- provider tax ID number, if known
- name of enrollee
- enrollee's ID number
- name of patient
- description of each service or purchase
- information on any other group health insurance plan(s) under which you may be covered
- accident information, if applicable
- proof of payment, if applicable

If the proof of payment you receive from a provider contains information in a foreign language, please provide the Plan with a translation of this information, if possible.

The UniCare State Indemnity Plan claim form may be used to submit written proof of a claim. For your convenience, a claim form can be found in Appendix E at the back of this Handbook.  You can also print or request this form from [www.unicarestatementplan.com](http://www.unicarestatementplan.com) (click on "Forms and Documents").

Original bills or paid receipts from providers will also be accepted as long as the information described above is included.

### Filing Deadline

Written proof of a claim must be submitted to the Plan within two years from the date of service. Claims submitted after two years will be accepted for review if it is shown that the person submitting the claim was mentally or physically incapable of providing written proof of the claim in the required time frame.

### Checking Your Claims for Billing Accuracy

#### Bill Checker Program

The goal of the Bill Checker Program is to detect overpayments that are the result of billing errors that only you, as the patient, may recognize. Just as you might do with your utility bills, the Plan encourages you to review all of your medical bills for accuracy. In those instances where you do detect a billing error and you are able to obtain a corrected bill from your provider, you will share in any actual savings realized by the Plan.

#### What You Need to Do

You must request that the provider send you an itemized bill for the services you received. As soon as possible, review this bill for any charges that indicate treatment, services or supplies that you did not receive. Check items such as:

- Did you receive the therapy described on the bill?
- Did you receive x-rays as indicated on your bill?
- Are there duplicate charges on the same bill?
- Have you been charged for more services than you received?
- Did you receive the laboratory services described on the bill?
- Does the room charge reflect the correct number of days?
- Were you charged for the correct type of room?




## Your Claims

### When Errors Are Detected

If you find an error, contact the provider or the provider's billing office and report the exact charges you are questioning. Request an explanation of any discrepancies and ask for a revised itemized bill showing any adjustments.

### How to Receive Your Share of the Savings

To receive your share of the savings, you must send copies of both the original and revised bill(s) to the Plan, along with the completed Bill Checker form. For your convenience, a Bill Checker form can be found in Appendix F at the back of this Handbook.

 You can also request this form from [www.unicarestateplan.com](http://www.unicarestateplan.com). Be sure to include the enrollee's name and identification number on the Bill Checker form. The Plan will review the two bills and, if a billing error is confirmed, you will receive 25% of any savings that the Plan realizes. All reimbursements are subject to applicable state and federal income taxes.

### Provider Bills Eligible under the Program

All bills for which UniCare provides the primary benefits are eligible under the Bill Checker Program. Bill Checker is not applicable to members who have Medicare as their primary coverage. This program may not apply to certain inpatient bills paid under the Diagnosis Related Group (DRG) methodology. Bills for prescription drugs and mental health/substance abuse services are excluded.

### Claims Review Process

The PLUS Plan routinely reviews submitted claims to evaluate the accuracy of billing information about services performed. The Plan may request written documentation such as operative notes, procedure notes, office notes, pathology reports and x-ray reports from your provider. In cases of suspected claim abuse or fraud, the Plan may require that the person whose disease, injury or pregnancy is the basis of the claim be examined by a physician chosen by the Plan. This examination must be approved by the Executive Director of the GIC and will be performed at no expense to the member.

### Restrictions on Legal Action

No legal action or suit to recover benefits for charges incurred while covered under the PLUS Plan may be started before 60 days after written proof of a claim has been furnished. Further, no such action or suit may be brought more than three years after the time such proof has been furnished. If either time limit is less than permitted by state law in the state you lived in when the alleged loss occurred, the limit is extended to be consistent with that state law.


### Right of Reimbursement

The Plan will have a lien on any recovery made by you or your dependent(s) for an injury or disease to the extent that you or your dependent(s) received benefits for such injury or disease from the Plan. That lien applies to any recovery made by you or your dependent(s) from any person or organization that was responsible for causing such injury or disease, or from their insurers. Neither you nor your dependent(s) will be required to reimburse the Plan for more than the amount you or your dependent(s) recover for such injury or disease.

You or your dependent(s) must execute and deliver such documents as may be required, and do whatever is necessary to help the Plan in its attempts to recover benefits it paid on behalf of you or your dependent(s).

### Claims Inquiry


If you have questions about your claims, you can contact the Andover Service Center in one of the following ways to request a review of your claim:

- Call us at (800) 442-9300.
-  E-mail us from [www.unicarestateplan.com](http://www.unicarestateplan.com) by clicking on "Contact Us."
- Write to the UniCare State Indemnity Plan/PLUS, Claims Department, P.O. Box 9016, Andover, MA 01810-0916.

If you have additional information, please include it with your letter. You will be notified of the result of the investigation and of the final determination.

### 24-Hour Access to Claims Information

You can also check the status of your claims 24 hours a day, seven days a week in the following two ways:

1. Call us at (800) 442-9300 and select the option to access our automated information line, OR
2.  Log onto [www.unicarestateplan.com](http://www.unicarestateplan.com). Register by creating a user ID and password to protect the privacy of your information. Dependents age 18 or older can access their individual claims information by establishing their own user IDs and passwords.

### Coordination of Benefits (COB)

You and your dependent(s) may be entitled to receive benefits from more than one plan. For instance, you may be covered as a dependent under your spouse's plan in addition to coverage under your own plan, or your child may be covered under both plans. When you or your dependent(s) are covered by two or more plans, one plan is identified as the primary plan for coordination of benefits (COB) and determining the order of payment. Any other plan is then the secondary plan.

If the PLUS Plan is the primary plan, benefit payments will be made in accordance with the benefits payable under the Plan without taking the other plan's benefits into consideration. A secondary plan may reduce its benefits if payments were paid by the PLUS Plan. If another plan is primary, benefit payments under the PLUS Plan are determined in the following manner:

- (a) The PLUS Plan determines its covered expenses—in other words, what the Plan would pay in the absence of other insurance; then
- (b) The PLUS Plan subtracts the primary plan's benefits from the covered expenses determined in (a) above, and then
- (c) The PLUS Plan pays the difference, if any, between (a) and (b)

The term “**primary plan's benefit**” includes the benefit that would have been paid had the claim been filed with the other plan. For those plans that provide benefits in the form of services, the reasonable cash value of each service is considered as the charge and as the benefit payment. All COB is determined on a calendar year basis for that part of the year the person had coverage under the Plan.

For the purposes of COB, the term “**plan**” is defined as any plan, including HMOs, that provides medical or dental care coverage including, but not limited to, the following:

- group or blanket coverage
- group practice or other group prepayment coverage, including hospital or medical services coverage
- labor-management trustee plans
- union welfare plans
- employer organization plans
- employee benefit organization plans
- Coverage under a governmental plan, or coverage required or provided by law. This would include any legally required, no-fault motor vehicle liability insurance. This does not include a state plan under Medicaid or any plan when, by law, its benefits are in excess of those of any private insurance program or other non-governmental program.
- automobile no-fault coverage

The term “plan” does not include school-accident type plans, or coverage that you purchased on a non-group basis.

### Determining the Order of Coverage

The following are the rules by which the PLUS Plan and most other plans determine order of payment—that is, which plan is the primary plan and which plan is the secondary plan:

- (a) The plan without a COB provision is primary.
- (b) The plan that covers the person as an employee, member, or retiree (that is, other than a dependent) determines benefits before the plan that covers the person as a dependent.
- (c) The order of coverage for a dependent child who is covered under both parents' plans is determined as follows:
  - 1. The primary plan is the plan of the parent whose birthday falls first in the calendar year; or
  - 2. If both parents have the same birthday, the primary plan is the plan that has covered a parent for the longest period of time.

This is called the “**birthday rule**.” However, if the other plan has a rule based on the gender of the parent, and if the plans do not agree on the order of coverage, the rules of the other plan will determine the order.

- (d) The order of coverage for dependent children who are covered under more than one plan, and whose parents are divorced or separated, is determined in the following order:
  - 1. first, the plan of the parent who is decreed by the court as financially responsible for the health care expenses of the child
  - 2. second, if there is no court decree, the plan of the parent with custody of the child
  - 3. third, if the parent with custody of the child is remarried, the plan of the stepparent
  - 4. finally, the plan of the parent who does not have custody of the child

- (e) The plan that covers a person as an active employee (that is, someone who is not laid off or retired) determines benefits for that person and his or her dependent(s) before the plan that covers that same person as a retiree.

This is called the “**active before retiree**” rule.

However, if the other plan's rule is based on length of coverage, and if the plans do not agree on the order of coverage, the rules of the other plan will determine the order.

If none of the above rules can be applied when trying to determine the order of coverage, the plan that has covered the person longer determines benefits before the plan that has covered that same person for the shorter period of time.

### Right to Receive and Release Information

In order to fulfill the terms of this COB provision or any other provision of similar purpose:

- a claimant must provide the Plan with all necessary information
- the Plan may obtain from or release information to any other person or entity

### Facility of Payment

A payment made under another plan may include an amount that should have been paid under the PLUS Plan. If it does, the PLUS Plan may pay that amount to the organization that made the payment. That amount will be treated as if it were a benefit payable under the PLUS Plan. The PLUS Plan will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

### Right of Recovery

If the amount of payments made by the PLUS Plan is more than it should have been under the COB provision, the Plan may recover the excess from one or more of the following:

- the persons it has paid or for whom it has paid
- the insurance companies, or
- other organizations

The “amount of payments made” includes the reasonable cash value of any benefits provided in the form of services.

### Modification of Coordination of Benefits Provisions for Persons Enrolled in Medicare Parts A and/or B

The benefits for an enrollee or his/her dependent(s) covered under the PLUS Plan and enrolled in Medicare will be determined as follows:

- (a) Expenses payable under Medicare will be considered for payment only to the extent that they are covered under the PLUS Plan and/or Medicare.
- (b) In calculating benefits for expenses incurred, the total amount of those expenses will first be reduced by the amount of the actual Medicare benefits paid for those expenses, if any.
- (c) PLUS Plan benefits will then be applied to any remaining balance of those expenses.

### Special Provisions Applicable to Senior Employees and Senior Dependents Eligible for Medicare

A senior employee is an active employee age 65 or over who is eligible for medical coverage under the PLUS Plan. A senior dependent is the spouse, age 65 or older, of an active employee who qualifies as a dependent of the employee.

Senior employees and senior dependents may continue medical coverage under the PLUS Plan regardless of their eligibility for, or participation in, Medicare.

### Medical Coverage Primary to Medicare Coverage for the Disabled

A disabled employee is an employee covered under the PLUS Plan who is under age 65 and who is entitled to Medicare disability for reasons other than End Stage Renal Disease (ESRD). A disabled dependent is a dependent who is under age 65 and who is entitled to Medicare disability benefits for reasons other than ESRD.

Disabled employees and disabled dependents may continue their medical coverage under the PLUS Plan, regardless of their eligibility for, or participation in, Medicare.

### Health Care Coverage Primary to Medicare Coverage for Covered Persons Who Have End Stage Renal Disease

For all covered persons with ESRD, coverage under the PLUS Plan will be primary to Medicare during the Medicare ESRD waiting period and the Medicare ESRD coordination period.

“**End Stage Renal Disease (ESRD)**” means that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life.

“**Medicare ESRD Waiting Period**” is generally the first three months after starting dialysis. You are not entitled to Medicare until after the three-month waiting period. This waiting period can be waived or shortened if a member participates in a self-dialysis training program or is scheduled for an early kidney transplant, respectively.

“**Medicare ESRD Coordination Period**” is 30 months long and occurs **after** the ESRD waiting period. The ESRD coordination period begins on the date that Medicare became effective **or would have become effective on the basis of ESRD**.

During that 30-month period, the PLUS Plan, for the purpose of the COB provision, is the primary payer and Medicare is the secondary payer. After the 30 months, Medicare becomes the primary payer while the Plan becomes the secondary payer. At this point, you must change health plans. Contact the GIC at:

**Group Insurance Commission**

P.O. Box 8747  
Boston, MA 02114-8747

### Appeal Rights

You have the right to appeal a benefit determination made by the PLUS Plan within 60 days of the notification of the determination. Your appeal should state why you believe the final determination was in conflict with the Plan provisions. You should also include all supporting documentation (at your own expense) that you or your health care provider believes supports your position.

The Plan will conduct a review of the submitted documentation, and a decision will be made within 30 days after receipt of your written request. The results of the appeal review will be sent to you in writing. The letter will contain the specific reasons for the Plan's decision and, if applicable, instructions as to any additional appeal procedures that may be available.

Appeals relating to the Managed Care Review Program (inpatient hospital admissions, certain outpatient diagnostic and surgical procedures, durable medical equipment, home health care, physical and occupational therapy, and chiropractic and osteopathic manipulation) should be directed to:

**UniCare State Indemnity Plan/PLUS**

Appeals Review  
P.O. Box 2011  
Andover, MA 01810-0035

All other appeals should be directed to:

**UniCare State Indemnity Plan/PLUS**

Appeals Review  
P.O. Box 2075  
Andover, MA 01810-0037

### Request and Release of Medical Information

The GIC's policies for releasing and requesting medical information comply with the Health Insurance Portability and Accountability Act (HIPAA). For more details, refer to the GIC's Notice of Privacy Practices in Appendix A at the back of this Handbook.



# Managed Care Program

## Overview

The Managed Care Program under the PLUS Plan includes the following components:

1. Managed Care Notification Requirements
2. Utilization Management
3. Medical Case Management
4. Quality Centers and Designated Hospitals for Transplants

The Managed Care Program determines the medical necessity and appropriateness of certain health care services by reviewing clinical information. This process, called Utilization Management, a standard component of most health care plans, ensures that benefits are paid appropriately for services that meet the Plan's definition of medical necessity. Managed Care Program staff will inform you in advance regarding what services will be covered. This Program helps control costs while preserving the ability of the Group Insurance Commission to offer the benefits of an indemnity plan to members.


These criteria are developed with input from actively practicing physicians in the Plan's service area, and are developed in accordance with the standards adopted by the national accreditation organizations. They are updated at least three times a year, or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice. These criteria are evidence-based, whenever possible. Managed Care Program staff will inform you or your provider in advance regarding what services will be covered.

The Managed Care Program staff includes patient advocates who are registered nurses and other nurse reviewers working with physician advisors. To determine medical necessity, nurses speak with your physicians, hospital staff, and/or other health care providers to evaluate your clinical situation and the circumstances of your health care. A physician advisor may speak with your physician on behalf of the Managed Care Program to discuss the proposed treatment and/or the setting in which it will be provided.

## Managed Care Notification Requirements

The review process is initiated when you, or someone on your behalf, notifies the Andover Service Center that:

- you or your dependent will be or has been admitted to the hospital; or
- a provider has recommended one of the procedures or services noted on the Notification Requirements chart on the following pages.

 You will also find the Plan's Notification Requirements on the Plan's web site: [www.unicarestatplan.com](http://www.unicarestatplan.com).

**When you use any provider inside or outside Massachusetts, you are responsible for meeting the managed care notification requirements.**

**Important: If you, or your provider, fail to notify the Andover Service Center by calling (800) 442-9300 within the required time frame as specified in the Notification Requirements chart starting on page 20, your benefits may be reduced by as much as \$500. The purpose of notifying the Plan is to give the Plan sufficient time to determine if the proposed service(s) will be covered. This process minimizes your risk of incurring charges for service(s) that are not covered by the Plan.**

When you call the Plan to give notification of an admission or service, please have the following information available:

- The hospital admission date or the start of service date
- The name, address and phone number of the admitting or referring physician, as well as the fax number if possible
- The name, address and phone number of the facility or vendor, as well as the fax number if possible

Please refer to the following pages for specific notification requirements and responsibilities.

## Managed Care Program

### Managed Care Notification Requirements†

| Treatment / Service   | Notification Requirement  |
|---|---|
| An Overnight Hospital Stay: <ul style="list-style-type: none"> <li>▪ Non-emergency Admission</li> <li>▪ Emergency Admission</li> <li>▪ Maternity Admission</li> </ul>   | At least 7 calendar days before the admission<br>Within 24 hours (next business day)<br>As soon as you know your expected due date or at least 7 days in advance of your admission<br><b>(you must also call again within one business day of being admitted to the hospital)</b> |
| Organ Transplants: Liver, Lung, Kidney, Heart, Bone Marrow, Simultaneous Kidney and Pancreas, All Other   | At least 21 calendar days before transplant-related services begin  |
| Durable Medical Equipment (if the purchase price exceeds \$500 or the expected rental charges will exceed \$500 over the period of use)   | At least one business day before ordering the equipment   |
| Home Health Care Provided By: <ul style="list-style-type: none"> <li>▪ Home Health Agencies</li> <li>▪ Visiting Nurse Associations</li> <li>▪ Home Infusion Therapy Companies</li> <li>▪ Private Duty Nurses</li> </ul> | At least one business day before the services begin   |
| Manipulative Therapy Provided By: <ul style="list-style-type: none"> <li>▪ Chiropractors</li> <li>▪ Medical and Osteopathic Physicians</li> </ul>   | At least one business day before your first appointment date  |
| Physical Therapy  | At least one business day before your first appointment date  |
| Occupational Therapy  | At least one business day before your first appointment date  |

 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300.

† Claims submission does not constitute notification.

## Managed Care Notification Requirements<sup>†</sup> (cont'd)

| Treatment / Service   | Notification Requirement  |
|---|---|
| <b>Selected Procedure Review:</b><br>(Some of the procedures listed below may be performed in a doctor's office.)   | At least seven (7) calendar days before the procedure for <b>non-emergency</b> procedures. If you are not sure whether the procedure is subject to these notification requirements, please call the Andover Service Center at (800) 442-9300. |
| Procedure   | Definition  |
| Arthroscopy of the knee for diagnostic purposes only  | Examination of the interior of the knee using an endoscope that is inserted into the joint through a small incision   |
| Cholecystectomy   | Removal of the gallbladder by any method  |
| CT Scans – Computerized Axial Tomography: <ul style="list-style-type: none"> <li>▪ Abdomen and/or Pelvis</li> <li>▪ Cervical Spine</li> <li>▪ Thoracic Spine</li> <li>▪ Lumbosacral Spine</li> <li>▪ Thoracic Cavity</li> </ul> | Special computerized x-ray of the abdomen or pelvis<br>Special computerized x-ray of the neck<br>Special computerized x-ray of the middle back<br>Special computerized x-ray of the lower back<br>Special computerized x-ray of the chest     |
| Dilation and Curettage (D & C)  | Stretching the cervix and removing or destroying the endometrial lining   |
| Discectomy of the Lumbosacral Spine   | Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lower back  |
| Hysterectomy  | Removal of the uterus (through the abdomen or vagina) by any method   |
| Hysteroscopy and/or Hysteroscopic Endometrial Ablation  | Examination through a telescopic tube (hysteroscope) of the inside of the uterus for diagnosis and/or treatment such as removal or destruction of the endometrial lining or lesions such as fibroids or polyps                                |
| Laminectomy/Laminotomy of the Lumbosacral Spine   | Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lumbosacral spine (lower back)  |

 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300.

<sup>†</sup> Claims submission does not constitute notification.

## Managed Care Notification Requirements<sup>†</sup> (cont'd)

| Procedure   | Definition   |
|---|--|
| MRI – Magnetic Resonance Imaging: <ul style="list-style-type: none"> <li>▪ Abdomen and/or Pelvis</li> <li>▪ Knee</li> <li>▪ Cervical Spine</li> <li>▪ Thoracic Spine</li> <li>▪ Lumbosacral Spine</li> <li>▪ Thoracic Cavity</li> </ul> | Imaging study of the abdomen or pelvis<br>Imaging study of the knee<br>Imaging study of the neck<br>Imaging study of the middle back<br>Imaging study of the lower back<br>Imaging study of the chest  |
| Pelvic Laparoscopy  | Examination through a telescopic tube (laparoscope) of the inside of the pelvis (the lower abdominal area) for diagnosis and/or treatment, aspiration, removal or destruction of abnormalities of the ovaries, fallopian tubes, uterus, female pelvic organs or surrounding structures |
| Sinus Surgery   | Any procedure by any method that opens, removes or treats the nasal sinuses  |
| Spinal Fusion of the Lumbosacral Spine  | Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lumbosacral spine (lower back)   |
| Spinal Instrumentation of the Lumbosacral Spine   | Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lumbosacral spine (lower back)   |
| UGI Endoscopy   | Examination through a flexible telescopic tube (endoscope) of the upper gastrointestinal (UGI) area (that is, the esophagus, stomach, and duodenum) for diagnosis and/or treatment   |

 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300.

<sup>†</sup> Claims submission does not constitute notification.

### Utilization Management Program

#### Inpatient Hospitalizations

**Initial Review:** The PLUS Plan must review and determine the medical necessity of all inpatient hospital admissions. You or someone on your behalf must initiate this process by calling the Andover Service Center at (800) 442-9300 at least seven (7) days in advance of a non-emergency admission, and within 24 hours or the next business day of an emergency admission.

The purpose of this process is to inform you whether the admission will be considered for benefits under the Plan prior to a non-emergency admission, or as soon as possible after an emergency admission. This minimizes your risk of incurring charges for non-covered services.

Upon notification, a patient advocate will contact your physician to discuss the medical necessity and appropriateness of the treatment plan and setting.

You and your physician will each receive a notice in the mail telling you if the Plan has confirmed the medical necessity and appropriateness of the admission. This notice will also specify the initial length of stay approved for the admission.

If the patient advocate is unable to confirm the medical necessity and appropriateness of the treatment, the inpatient hospital setting or the anticipated length of stay, a physician advisor will attempt to speak with your physician before the Plan makes a final decision. If the Plan determines that the admission is not medically necessary and appropriate, the patient advocate will promptly notify you, your physician and the hospital.

**Continued Stay Review:** Your physician may recommend that you stay in the hospital beyond the initial number of days that the Plan has approved. In this case, the Plan will determine whether a continued hospital stay is medically necessary and appropriate. You do not have to contact the Plan. The patient advocate will stay in touch with your physician while you are in the hospital and work with the hospital staff to facilitate planning for care that may be required after your discharge.

If the patient advocate is unable to confirm that the continued hospitalization is medically necessary, a physician advisor will speak with your physician before the Plan makes a final decision. If the Plan determines that the continued stay is not medically necessary and appropriate, the patient advocate will promptly notify you, your physician and the hospital.

#### Durable Medical Equipment over \$500

Any Durable Medical Equipment (DME) ordered by a physician that is expected to cost more than \$500 is subject to Plan review. The \$500 cost may be the result of either the purchase price or the total rental charges.

The Plan must be notified at least one (1) business day before the equipment is ordered from the equipment provider. Upon notification, a patient advocate will contact your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the equipment. A patient advocate will notify you regarding whether the Plan will authorize coverage for the equipment.

If you obtain equipment through a Preferred Vendor, the authorized item will be covered at 100% of the allowed amount. Please note that if a covered item is not available through a Preferred Vendor, although it is authorized, it will only be covered at 80% of the allowed amount after the calendar year deductible.

#### Home Health Care

When a physician prescribes home health care services, the Plan must be notified at least one (1) business day before the services begin. Upon notification, a patient advocate will call your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the home health care services. A patient advocate will notify you or your provider regarding whether the Plan will authorize coverage for the services.



### Manipulative Therapy

Manipulative therapy refers to any hands-on treatment provided by a chiropractor or a medical or osteopathic physician. The Plan must be notified at least one (1) business day before the services begin. Upon notification, a patient advocate will call your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the manipulative therapy services.

### Physical Therapy

When a physician prescribes physical therapy services for you or for your dependent(s), the Plan must be notified one (1) business day before the date of your first appointment. A patient advocate will contact your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the physical therapy services.

Physical therapy must be ordered by a physician, and a copy of the order must be made available to the Plan upon request.

### Occupational Therapy

When a physician prescribes occupational therapy services for you or for your dependent(s), the Plan must be notified one (1) business day before the date of your first appointment. A patient advocate will contact your health care provider to obtain clinical information that will be used to determine the medical appropriateness of the occupational therapy services.

Occupational therapy must be ordered by a physician, and a copy of the order must be made available to the Plan upon request.

### Minimum Maternity Confinement Benefits

Coverage is provided for inpatient hospital services for a mother and newborn child for a minimum of:

1. 48 hours following an uncomplicated vaginal delivery, and
2. 96 hours following an uncomplicated caesarean section

Any decision to shorten the minimum confinement period will be made by the attending physician in consultation with the mother. If a shortened confinement is elected, coverage will include one home visit for post-delivery care.

Home post-delivery care is defined as health care provided to a woman at her residence by a physician, registered nurse or certified nurse midwife. The health care services provided must include, at a minimum:

1. parent education
2. assistance and training in breast or bottle feeding, and
3. performance of necessary and appropriate clinical tests

Any subsequent home visits must be clinically necessary and provided by a licensed health care provider.

You must notify the Plan as soon as you know your or your dependent(s)' expected due date or at least seven (7) days in advance of your admission. You must notify the Plan again within one (1) business day of being admitted to the hospital. Please call a patient advocate if you have any questions.

### Selected Procedures

Members scheduled on a non-emergency basis for one of the selected procedures listed on pages 21–22 must notify the Plan at least seven (7) calendar days before the scheduled date of the procedure. The Plan requires notification, whether the procedure is being done in a hospital on an inpatient or outpatient basis, in a freestanding facility or in a physician's office.

## Managed Care Program

If you are scheduled to have a procedure or special test done and you do not know the medical term for it, ask your physician to call the Andover Service Center at (800) 442-9300 to find out if prior notification is needed. Upon notification, a patient advocate will contact your physician to obtain clinical information that will be used to determine the medical necessity of the planned procedure and the appropriateness of the setting in which it will be provided.

If the patient advocate is unable to confirm the medical necessity and appropriateness of the planned procedure, a physician advisor will talk to your physician before a final decision is made. This decision will be communicated to you and your physician.

### Expedited Appeals Process

If an initial denial occurs before or while health care services are being provided, and the attending physician or patient believes that the determination warrants an immediate reconsideration, either party may request reconsideration of that determination over the telephone on an expedited basis.

For an immediate reconsideration, the Andover Service Center must receive the request and all supporting information within three (3) business days of the initial notification of denial. The reconsideration will be completed within two (2) business days of receipt of all necessary supporting documentation. The decision is then communicated in writing to the patient and the patient's health care provider.

If the denial is upheld, the patient can take the next step and appeal the decision to:

#### UniCare State Indemnity Plan/PLUS

Appeals Review

P.O. Box 2011

Andover, MA 01810-0035

### Medical Case Management Program

The Medical Case Management Program facilitates the timely provision of appropriate, cost-effective, quality health care services that are tailored to meet an individual's health care needs. A medical case manager is a registered nurse with the expertise to assist you and your family when you are faced with a serious medical problem such as stroke, cancer, spinal cord injury or other conditions that require multiple medical services. The medical case manager will:

- help you and your family cope with the stress associated with an illness or injury by facilitating discussions about health care planning, and enhance the coordination of services among multiple providers
- work with the attending physician and other involved health care providers to evaluate the present and future health care needs of the patient
- provide valuable information regarding available resources for the patient
- work with the mental health/substance abuse benefits administrator when you or your dependent's condition requires both medical and mental health services, to coordinate services and maximize your benefits under the Plan
- explore alternative funding sources or other resources in cases where medical necessity exists but there is a limit to coverage under the Plan
- facilitate the management of chronic disease states by promoting education, wellness programs, self-help and prevention
- promote the development of an appropriate plan of care to ease the transition from a stay in a facility to the return home

### Coronary Artery Disease Secondary Prevention Program

The Coronary Artery Disease Secondary Prevention Program is designed to help you make the necessary lifestyle changes that can reduce your cardiac risk factors. It is available to members with a history of heart disease. The program is available through the Medical Case Management Program. You may call a medical case manager at (800) 442-9300 to ask about your eligibility and available programs.

### Quality Centers and Designated Hospitals for Transplants

The PLUS Plan has designated certain hospitals as Quality Centers for organ transplants. These hospitals were chosen for their specialized programs, experience, reputation and ability to provide high quality care. The purpose of this program is to facilitate the provision of timely, cost-effective, quality services to eligible Plan members at specialized facilities. A medical case manager is available to support the patient and family before the transplant procedure and throughout the recovery period. To speak with a medical case manager, call (800) 442-9300. He or she will:

- assess the patient's ongoing needs
- coordinate services while the patient is awaiting a transplant
- help the patient and family to optimize Plan benefits

- maintain communication with the transplant team
- facilitate transportation and housing arrangements, if needed
- facilitate discharge planning alternatives
- coordinate home care plans as necessary
- explore alternative funding sources or other resources in cases where there is need but there are limited benefits under the Plan

Although members have the freedom to choose any health care provider for these procedures, you can maximize your benefits when you use one of these Quality Centers. You, or someone on your behalf, should notify the Plan as soon as your physician recommends a transplant evaluation.


## Benefit Highlights


### A Summary of Your Medical Benefits


This section contains a summary of your medical benefits under the PLUS Plan, as follows:

- the level of benefits coverage – either with a PLUS or a non-PLUS provider. PLUS providers consist of all Massachusetts providers (except for non-Preferred Vendors), and non-Massachusetts providers in the UniCare provider network. Non-PLUS providers are providers outside Massachusetts that are not part of the UniCare provider network.
- any coinsurance, copays, or deductibles you are responsible for paying in connection with a service or supply (for copay and deductible amounts, please refer to the Your Costs section)
- any limits on the maximum number of visits allowed per calendar year
- any maximum dollar amounts per calendar year that are associated with a service or supply

**Important:** The information contained in this section is only a summary of your medical benefits. For additional details of your medical plan benefits coverage, please refer to the Description of Covered Services section of this Handbook, which follows the Benefit Highlights section.

Look for the **book symbol**  next to each service listed in the Benefit Highlights section for the corresponding page in the Description of Covered Services section or other sections where this benefit is more fully described.


The **telephone symbol**  you see throughout this Handbook lets you know that, to obtain the maximum level of benefits, you or your provider must call the Andover Service Center at (800) 442-9300. Failure to do so will result in a reduction in benefits of up to \$500. However, you do not need to call the Plan if you are outside the continental United States (the contiguous 48 states). Please refer to the Managed Care Program section of this Handbook (the preceding section) for more information regarding the notification requirements associated with these benefits.

The **computer symbol**  that you see throughout this Handbook indicates that information on the highlighted topic is available on the Plan's web site, [www.unicarestateplan.com](http://www.unicarestateplan.com).

## Benefit Highlights

### Summary of Covered Services



| PLUS Provider   |  | Non-PLUS Provider  |
|---|--|--|
|  <b>Inpatient Hospital Services</b><br>in an Acute Medical, Surgical or Rehabilitation Facility  |  |  Also see page 37   |
| Semi-Private Room, ICU, CCU and Ancillary Services  | 100% after the inpatient hospital quarterly deductible   | 80% after the inpatient hospital quarterly deductible  |
| Medically Necessary Private Room  | 100% for the first 90 days in a calendar year after the inpatient hospital quarterly deductible; then 100% at the semi-private level | 80% for the first 90 days in a calendar year after the inpatient hospital quarterly deductible; then 80% at the semi-private level. The 20% coinsurance amount does not count toward the out-of-pocket maximum |
| Inpatient Diagnostic Laboratory and Radiology (including high-tech imaging)   | 100%   | 80%  |
|  <b>Select Complex Inpatient Procedures and High-Risk Deliveries and Neonatal ICUs</b><br>(See Appendix D for list of procedures and hospitals.) |  |  Also see page 52   |
| Select Complex Inpatient Procedures and High-Risk Deliveries and Neonatal ICUs  | 100% after the inpatient hospital quarterly deductible at a Designated Hospital  | 80% after the inpatient hospital quarterly deductible  |
|  <b>Transplant Services</b>  |  |  Also see pages 43–44   |
| Quality Centers and Designated Hospitals for Transplants  | 100% after the inpatient hospital quarterly deductible   | 100% after the inpatient hospital quarterly deductible   |
| Other Hospitals   | 80% after the inpatient hospital quarterly deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.   | 80% after the inpatient hospital quarterly deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.   |

 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care section for specific notification requirements and responsibilities.

For your deductible and copay amounts, see the charts in the Your Costs section.

All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Summary of Covered Services






| PLUS Provider  |   | Non-PLUS Provider  |
|--|---|--|
| Other Inpatient Facilities   |   |  Also see page 37   |
| <ul style="list-style-type: none"><li>▪ Sub-acute Care Hospital/ Facility</li><li>▪ Transitional Care Hospital/ Facility</li><li>▪ Long-term Care Hospital/ Facility</li><li>▪ Chronic Disease Hospital/ Facility</li><li>▪ Skilled Nursing Facility</li></ul> | 80% up to a maximum of 45 days per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum. | 80% after the calendar year deductible up to a calendar year maximum of 45 days per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum. |
| Emergency Treatment for an Accident / Sudden Serious Illness   |   |  Also see pages 37–38   |
| Emergency Room Charge  | 100% after the emergency room copay; copay waived if admitted   | 100% after the emergency room copay; copay waived if admitted  |
| Radiology (including high-tech imaging)  | 100%  | 100%   |
| Diagnostic Laboratory  | 100%  | 100%   |


For your deductible and copay amounts, see the charts in the Your Costs section.  
All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.



## Benefit Highlights

### Summary of Covered Services

| PLUS Provider  |   | Non-PLUS Provider  |
|--|---|--|
| <b>Non-Emergency Treatment</b>   |   |  Also see pages 37–38 |
| Emergency Room Charge  | 100% after the emergency room copay; waived if admitted     | 100% after the emergency room copay (waived if admitted) and after the calendar year deductible          |
| Radiology (other than high-tech imaging)   | 100%  | 80%  |
|  High-Tech Imaging (such as MRIs, CT scans and PET scans) as part of an emergency room treatment and/or as part of inpatient care | 100%  | 80%  |
|  High-Tech Imaging (such as MRIs, CT scans and PET scans)   | 100% after the copay per scan; maximum of one copay per day | 80% after the copay per scan; maximum of one copay per day   |
| Diagnostic Laboratory  | 100%  | 80%. The 20% coinsurance amount does not count toward the out-of-pocket maximum.                         |
|  <b>Surgery</b>   |   |  Also see page 38   |
| Inpatient  | 100%  | 80%  |
| Outpatient Surgery at a Hospital   | 100% after the outpatient surgery quarterly deductible      | 80% after the outpatient surgery quarterly deductible  |
| Surgery at an Ambulatory Surgical Facility or Physician's Office   | 100%  | 80%  |





 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care section for specific notification requirements and responsibilities.

For your deductible and copay amounts, see the charts in the Your Costs section.


All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

Benefit Highlights

Summary of Covered Services

| PLUS Provider  |   | Non-PLUS Provider  |
|--|---|--|
| Outpatient Medical Care  |   |  Also see pages 38–43 |
| For Services at a Hospital (other than the services listed below)  | 100%  | 80% after the calendar year deductible   |
| Diagnostic Laboratory Testing  | 100%  | 80%. The 20% coinsurance amount does not count toward the out-of-pocket maximum.                         |
| Radiology (other than high-tech imaging)   | 100%  | 80%  |
|  High-Tech Imaging such as MRIs, CT scans and PET scans   | 100% after the copay per scan; maximum of one copay per day | 80% after the copay per scan; maximum of one copay per day   |
| Licensed Retail Medical Clinics at Pharmacies  | 100% after the copay  | 80% after the copay and after the calendar year deductible   |
|  Physical Therapy and  Occupational Therapy | 100% after the applicable copay                             | 100% after the applicable copay and after the calendar year deductible                                   |
| Speech Therapy   | 100% up to a maximum benefit of \$2,000 per calendar year   | 80% after the calendar year deductible up to a maximum benefit of \$2,000 per calendar year              |
| Chemotherapy   | 100%  | 80% after the calendar year deductible   |

Benefit Highlights  
Covered Services







 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care section for specific notification requirements and responsibilities.


For your deductible and copay amounts, see the charts in the Your Costs section.


All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

## Benefit Highlights

### Summary of Covered Services

| PLUS Provider  |   | Non-PLUS Provider  |
|--|---|--|
| <b>Physician Services</b>  |   |  Also see page 42   |
| Non-Emergency Treatment at Home, Office or Outpatient Hospital   | 100% after the applicable office visit copay per visit.   | 80% after the applicable office visit copay per visit and after the calendar year deductible.  |
| Hospital Inpatient   | 100%  | 80%  |
| Emergency Treatment  | 100%  | 100%   |
|  Chiropractic Care or Treatment | 80% after the chiropractic visit copay; maximum benefit of \$40 per visit, 20 visits per calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum.   | 80% after the chiropractic visit copay and after the calendar year deductible; maximum benefit of \$40 per visit, 20 visits per calendar year. The 20% coinsurance amount does not count toward the calendar year deductible or the out-of-pocket maximum.   |
| <b> Private Duty Nursing</b>  |   |  Also see page 43   |
| Provided in Home Setting Only  | 80% for a registered nurse up to a calendar year maximum benefit of \$8,000. Of this \$8,000, up to \$4,000 may be for licensed practical nurse services if no registered nurse is available. The 20% coinsurance amount does not count toward the out-of-pocket maximum. | 80% for a registered nurse up to a calendar year maximum benefit of \$8,000 after the calendar year deductible. Of this \$8,000, up to \$4,000 may be for licensed practical nurse services if no registered nurse is available. The 20% coinsurance amount does not count toward the out-of-pocket maximum. |
| <b> Home Health Care</b>      |   |  Also see pages 40–41   |
| Medicare Certified Home Health Agencies and Visiting Nurse Associations <sup>1</sup>                             | 80%   | 80% after the calendar year deductible   |

<sup>1</sup> A program is available to enhance the benefit for Home Health Care by using Preferred Vendors.  Check the list of Preferred Vendors at [www.unicarestateplan.com](http://www.unicarestateplan.com), or call the Andover Service Center at (800) 442-9300 for more information.





 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care section for specific notification requirements and responsibilities.

For your deductible and copay amounts, see the charts in the Your Costs section.

All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.


## Benefit Highlights

### Summary of Covered Services

| PLUS Provider  |  | Non-PLUS Provider   |
|--|--|---|
|  <b>Home Infusion Therapy</b> |  |  Also see page 54  |
|  | 100% with a Preferred Vendor <sup>1</sup><br>80% with a non-Preferred Vendor after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum. | 80% after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.   |
| <b>Preventive Care</b>   |  |  Also see pages 42–43  |
| Office Visits<br>(refer to frequency limits on pages 42–43)  | 100% after the applicable copay per visit  | 80% after the applicable copay per visit  |
| Annual Gynecological Visits  | 100% after the applicable copay per visit  | 80% after the applicable copay per visit  |
| Immunizations  | 100%   | 100%  |
| Covered Laboratory Testing <sup>2</sup>  | 100% <sup>2</sup>  | 80% <sup>2</sup> . The 20% coinsurance does not count toward the out-of-pocket maximum.   |
| <b>Hospice</b>   |  |  Also see page 44  |
| Medicare Certified Hospice   | 100%   | 80% after the calendar year deductible  |
| Bereavement Counseling   | 80% up to a maximum benefit of \$1,500 per family. The 20% coinsurance amount does not count toward the out-of-pocket maximum.   | 80% up to a maximum benefit of \$1,500 per family after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum. |

<sup>1</sup> For a list of the Plan's Preferred Vendors, log onto [www.unicarestateplan.com](http://www.unicarestateplan.com) and click on "All Provider Listings" under "Find a Provider."

<sup>2</sup> For information on covered preventive laboratory services, see the preventive care schedule on pages 42–43.






 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care section for specific notification requirements and responsibilities.


For your deductible and copay amounts, see the charts in the Your Costs section.


All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

## Benefit Highlights

### Summary of Covered Services

| PLUS Provider  |  | Non-PLUS Provider  |
|--|--|--|
| <b>Early Intervention Services for Children</b>  |  |  Also see page 40   |
| Programs Approved by the Department of Public Health   | 80% up to a maximum benefit of \$5,200 per child per calendar year, and a lifetime maximum benefit of \$15,600. The 20% coinsurance does not count toward the out-of-pocket maximum.             | 80% up to a maximum benefit of \$5,200 per child per calendar year, and a lifetime maximum benefit of \$15,600. The 20% coinsurance does not count toward the out-of-pocket maximum. |
| <b>Ambulance</b>   |  |  Also see page 38   |
|  | 100%   | 100% of the first \$25; then 80% after the calendar year deductible  |
| <b>Coronary Artery Disease (CAD) Secondary Prevention Program</b>  |  |  Also see page 26   |
| Designated Programs Available Through Medical Case Management  | 90%. The 10% coinsurance does not count toward the out-of-pocket maximum.  | Not covered  |
|  <b>Durable Medical Equipment (DME)</b> |  |  Also see page 45   |
|  | 100% with a Preferred Vendor <sup>1</sup><br><br>80% with a non-Preferred Vendor after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum. | 80% after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.  |

<sup>1</sup> If an item is not available through a Preferred Vendor and you obtain it from another provider, it will be covered at 80%.  For a list of the Plan's Preferred Vendors, log onto [www.unicarestateplan.com](http://www.unicarestateplan.com) and click on "All Provider Listings" under "Find a Provider."





 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care section for specific notification requirements and responsibilities.

For your deductible and copay amounts, see the charts in the Your Costs section.

All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

## Benefit Highlights

### Summary of Covered Services

| PLUS Provider  |  | Non-PLUS Provider   |
|--|--|---|
| <b>Hospital-Based Personal Emergency Response Systems (PERS)</b> |  |  Also see page 45  |
| Installation   | 80% up to a maximum benefit of \$50. The 20% coinsurance amount does not count toward the out-of-pocket maximum.   | 80% up to a maximum benefit of \$50 after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.   |
| Rental Fee   | 80% up to a maximum benefit of \$40 per month. The 20% coinsurance amount does not count toward the out-of-pocket maximum.   | 80% up to a maximum benefit of \$40 per month after the calendar year deductible. The 20% coinsurance amount does not count toward the out-of-pocket maximum.   |
| <b>Prostheses<sup>1</sup></b>                                    |  |  Also see page 43  |
|  | 80%  | 80% after the calendar year deductible  |
| <b>Braces<sup>2</sup></b>  |  |  Also see page 39  |
|  | 80%  | 80% after the calendar year deductible  |
| <b>Hearing Aids</b>  |  |  Also see page 40  |
|  | 100% of the first \$500; then 80% of the next \$1,500, up to a maximum benefit of \$1,700 every two years. The 20% coinsurance amount does not apply to the out-of-pocket maximum. | 100% of the first \$500 after the calendar year deductible; then 80% of the next \$1,500, up to a maximum benefit of \$1,700 every two years. The 20% coinsurance amount does not apply to the out-of-pocket maximum. |

<sup>1</sup> Breast prostheses are covered at 100% when you use a PLUS provider, or at 100% after the calendar year deductible when you use a non-PLUS provider.

<sup>2</sup> Orthopedic shoe(s) with attached brace is covered at 100% when you use a Preferred Vendor, or at 100% after the calendar year deductible when you do not use a Preferred Vendor.





For your deductible and copay amounts, see the charts in the Your Costs section.

All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.




## Benefit Highlights

### Summary of Covered Services


| PLUS Provider                                      |  | Non-PLUS Provider   |
|--|--|---|
| Eyeglasses / Contact Lenses                        |  |  Also see page 51            |
|  | 80%. Limited to the initial set within six months following cataract surgery | 80% after the calendar year deductible. Limited to the initial set within six months following cataract surgery |
| Routine Eye Examinations<br>(including refraction) |  |  Also see pages 49 & 51      |
|  | 100% after the applicable copay. Covered once every 24 months.               | 80% after the applicable copay. Covered once every 24 months.   |
| Family Planning Services                           |  |  Also see page 40            |
| Office Visits and Procedures                       | 100% after the applicable copay per visit                                    | 100% after the applicable copay per visit and after the calendar year deductible                                |
| All Other Covered Medical Services                 |  |  Also see pages 38–46      |
|  | 80%  | 80% after the calendar year deductible  |

### Prescription Drug Plan – Benefits Administered by Express Scripts.

 See page 69.

For more information, call (877) 828-9744.

### Mental Health, Substance Abuse and Employee Assistance Programs – Benefits Administered by United Behavioral Health.

 See page 79.

For more information, call (888) 610-9039.

For your deductible and copay amounts, see the charts in the Your Costs section.

All services must be medically necessary and all charges will be subject to the Reasonable and Customary Allowed Amount.

## Description of Covered Services

The following pages contain descriptions of various covered services under the PLUS Plan. Please refer to the Benefit Highlights section for information regarding benefit percentages and maximums, copays, coinsurance amounts, deductibles, out-of-pocket maximum amounts and durations of benefits that apply to these covered services. (For copay and deductible amounts, see the Your Costs section.)

The Benefit Highlights section also shows you the difference in the level of coverage when you use PLUS providers versus non-PLUS providers. For information on the Plan's medical review requirements and to find out when prior authorization is needed, please refer to the Managed Care Program section.

### Inpatient Hospital Services

Charges for the following services qualify as covered hospital charges if the services are for a hospital stay.

1. Room and board provided to the patient
2. Anesthesia, radiology and pathology services
3. Hospital pre-admission testing if you or your covered dependent(s) is scheduled to enter the same hospital where the tests are performed within seven (7) days after they are performed. If the hospital stay is cancelled or postponed after the tests are performed, the charges will still be covered as long as the physician presents a satisfactory medical explanation.
4. Medically necessary services and supplies charged by the hospital, except for special nursing or physician services
5. Physical, occupational and speech therapy
6. Diagnostic and therapeutic services

### Services at Other Inpatient Facilities

Other inpatient facilities include:

- Sub-acute Care Hospitals/Facilities
- Transitional Care Hospitals/Facilities
- Long-term Care Hospitals/Facilities

- Chronic Disease Hospitals/Facilities
- Skilled Nursing Facilities

Covered charges for these facilities include the following services:


1. Room and board
2. Routine nursing care, but not including the services of a private-duty nurse or other private-duty attendant
3. Physical, occupational and speech therapy provided by the facility or by others under arrangements with the facility
4. Such drugs, biologicals, medical supplies, appliances, and equipment as are ordinarily provided by the facility for the care and treatment of its patients
5. Medical social services
6. Diagnostic and therapeutic services furnished to patients of the facility by a hospital or any other health care provider
7. Other medically necessary services as are generally provided by such treatment facilities

#### Coverage in "Other Inpatient Facilities"

**NOTE:** To qualify for coverage in "Other Inpatient Facilities," the purpose of the care in these facilities must be the reasonable improvement in the patient's condition. A physician must certify that the patient needs and receives, at a minimum, skilled nursing or skilled rehabilitation services on a daily or intermittent basis. Continuing care for a patient who has not demonstrated reasonable clinical improvement is not covered.

### Emergency Treatment for an Accident or Sudden/Serious Illness

An emergency is an illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected by a prudent

 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care Program section for specific notification requirements and responsibilities.

## Description of Covered Services

layperson, who possesses an average knowledge of health and medicine, to result in serious jeopardy to physical and/or mental health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or, in the case of pregnancy, a threat to the safety of a member or her unborn child.

Massachusetts provides a 911 emergency response system throughout the state. The Plan will cover medical and transportation expenses incurred as a result of the emergency medical condition in accordance with the terms of the Plan. If you are faced with an emergency, call 911. In other states, check with your local telephone company about emergency access numbers. Keep emergency numbers and the telephone numbers of your physicians in an easily accessible location.

### Surgical Services

The payment to a surgical provider for operative services includes the usual pre-operative, intra-operative and post-operative care.

Charges for the following services qualify as covered surgical charges:

1. Medically necessary surgical procedures when performed on an inpatient or outpatient basis (hospital, physician's office or surgical center)
2. Services of an assistant surgeon when:
  - (a) medically necessary
  - (b) the assistant surgeon is trained in a surgical specialty related to the procedure and is not a fellow, resident or intern in training, and
  - (c) the assistant surgeon serves as the first assistant surgeon. (Second or third assistants are not covered.)
3. Reconstructive breast surgery:
  - (a) All stages of breast reconstruction following a mastectomy
  - (b) Reconstruction of the other breast to produce a symmetrical appearance after mastectomy

- (c) Coverage for prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas


Benefits for reconstructive breast surgery will be payable on the same basis as any other illness or injury under the Plan, including the application of appropriate deductibles and coinsurance amounts. Several states have enacted similar laws requiring coverage for treatment related to mastectomy. If the law of your state is more generous than the federal law, your benefits will be paid in accordance with your state's law.

4. All other reconstructive and restorative surgery, but limited to the following:
  - (a) Reconstruction of defects resulting from surgical removal of an organ or body part for the treatment of cancer. Such restoration must be within five (5) years of the removal surgery.
  - (b) Correction of a congenital birth defect that causes functional impairment for a minor dependent child.

### Medical Services

Charges for the following services qualify as covered medical charges, but only if they do not qualify as covered hospital or surgical charges:

1. **Ambulance/Air Ambulance** – only in the event of an emergency and when medically necessary. Benefits are payable only for transportation to the nearest facility equipped to treat the condition. Transportation to or from medical appointments, including dialysis, is not a covered service.
2. **Anesthesia** and its administration
3. **Audiology Services** – expenses for the diagnosis of speech, hearing and language disorders are covered when provided by a licensed audiologist when the services are provided in a hospital,

 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care Program section for specific notification requirements and responsibilities.

## Description of Covered Services

clinic or private office. Services provided in a school-based setting are not covered. The Plan does not cover services that a school system is obligated to provide under Chapter 766 in Massachusetts or under similar laws in other states.

4. **Braces** – replacement of such equipment is also covered when required due to pathological change or normal growth.

Also see Orthotics.

5. **Cardiac Rehabilitation Treatment** – provided by a cardiac rehabilitation program (see definition on page 52).
6. **Certified Nurse Midwife Services** – provided in the home or in a hospital.
7. **Circumcision** – when provided for newborns up to 30 days from birth.
8. **Crutches** – replacement of such equipment is covered when required due to pathological change or normal growth.
9. **Diabetes** – benefits will be paid for charges incurred by a covered person for medically necessary equipment, supplies and medications for the treatment of diabetes. Coverage will include outpatient self-management training and patient management, as well as nutritional therapy.

Coverage will apply to services and supplies prescribed by a doctor for insulin dependent, insulin using, gestational and non-insulin using diabetes. The PLUS Plan will provide benefits for these services and supplies when prescribed by a physician under the medical component of the Plan or under the prescription drug plan as indicated below.

**Diabetic drugs, insulin and the following diabetic supplies are covered under the prescription drug component of the Plan:**

- (a) blood glucose monitors
- (b) test strips for glucose monitors
- (c) insulin
- (d) syringes and all injection aids
- (e) lancets and lancet devices
- (f) prescribed oral agents
- (g) glucose agents and glucagon kits
- (h) urine test strips

**The following diabetic supplies are covered under the medical component of the Plan:**

- (a) blood glucose monitors, including voice synthesizers for blood glucose monitors for use by legally blind persons
- (b) test strips for glucose monitors
- (c) laboratory tests, including glycosylated hemoglobin (HbA1c) tests, urinary protein/microalbumin and lipid profiles
- (d) insulin pumps and all related supplies
- (e) insulin infusion devices
- (f) syringes and all injection aids
- (g) lancets and lancet devices
- (h) urine test strips
- (i) insulin measurement and administration aids for the visually impaired
- (j) podiatric appliances for the prevention of complications associated with diabetes

## Description of Covered Services

### Diabetes Self-Management Training

Diabetes self-management training and patient management, including medical nutritional therapy, may be conducted individually or in a group, but must be provided by:

- an education program recognized by the American Diabetes Association, or
- a health care professional who is a diabetes educator certified by the National Certification Board for Diabetes Educators


Coverage will include all educational materials for such program. Benefits will be provided as follows:

- (a) upon the initial diagnosis of diabetes
- (b) when a significant change occurs in symptoms or conditions, requiring changes in self-management
- (c) when refresher patient management is necessary, or
- (d) when new medications or treatments are prescribed

As used in this provision, “patient management” means educational and training services furnished to a covered person with diabetes in an outpatient setting by a person or entity with experience in the treatment of diabetes. This will be in consultation with the physician who is managing the patient’s condition. The physician must certify that the services are part of a comprehensive plan of care related to the patient’s condition. In addition, the services must be needed to ensure therapy or compliance or to provide the patient with the necessary skills and knowledge involved in the successful management of the patient’s condition.


10. **Early Intervention Services for Children** – coverage of medically necessary Early Intervention Services for children from birth until their third birthdays includes occupational therapy, physical therapy, speech therapy,

nursing care, psychological counseling, and services provided by early intervention specialists or by licensed or certified health care providers working with an Early Intervention Services program approved by the Department of Public Health. See the Benefit Highlights section for benefit maximums.

11. **Family Planning Services** – office visits and procedures for the purpose of contraception. Office visits include evaluations, consultations and follow-up care. Procedures include fitting for a diaphragm or cervical cap; the insertion, re-insertion, or removal of an IUD or Levonorgestrel (Norplant); and the injection of progesterone (Depo-Provera). FDA approved contraceptive drugs and devices are available through the prescription drug plan.
12. **Gynecological Visits** – annual gynecological examination, including Pap smear.
13. **Hearing Aids** – when prescribed by a physician. See the Benefit Highlights section for benefit maximum.
14. **Hearing Screenings** for newborns.
15.  **Home Health Care** and skilled nursing services provided under a plan of care prescribed by a physician and delivered by a Medicare-certified Home Health Care agency. (Refer to definition of Home Health Care in Plan Definitions on page 54.)

The following services are only covered if the covered individual is receiving approved part-time, intermittent skilled care furnished or supervised by a registered nurse or licensed physical therapist:

- (a) Part-time, intermittent home health aide services consisting of personal care of the patient and assistance with activities of daily living

 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care Program section for specific notification requirements and responsibilities.

## Description of Covered Services

- (b) Physical, occupational, speech and respiratory therapy by the appropriate licensed or certified therapist
- (c) Nutritional consultation by a registered dietitian
- (d) Medical social services provided by a licensed medical social worker
- (e) Durable medical equipment (DME) and supplies provided as a medically necessary component of a physician-approved home health services plan.

However, the following charges do not qualify as covered home health care charges:

- (a) Charges for custodial care or homemaking services
- (b) Services provided by you, a member of your family or any person who resides in your home. Your family consists of you, your spouse and your children, as well as brothers, sisters and parents of both you and your spouse.

16. **Infertility Treatment** – non-experimental infertility procedures including, but not limited to:
- (a) Artificial Insemination (AI) also known as Inter-uterine Insemination (IUI)
  - (b) In Vitro Fertilization and Embryo Placement (IVF-EP)
  - (c) Gamete Intrafallopian Transfer (GIFT)
  - (d) Zygote Intrafallopian Transfer (ZIFT)
  - (e) Natural Ovulation Intravaginal Fertilization (NORIF)
  - (f) Cryopreservation of eggs as a component of covered infertility treatment (costs associated with banking and/or storing inseminated eggs are reimbursable only upon the use of such eggs for covered fertility treatment)



- (g) Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any
- (h) Donor sperm or egg procurement and processing, to the extent such costs are not covered by the donor's insurer, if any
- (i) Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility


In Vitro Fertilization and other associated infertility procedures, with the exception of artificial insemination, are limited to five (5) attempts (see definition of "Attempt" in the Plan Definitions section).

Charges for the following services are not considered covered services:

- (a) Experimental infertility procedures
- (b) Surrogacy
- (c) Reversal of voluntary sterilization
- (d) Procedures for infertility not meeting the Plan's definition on page 56.



Facility fees will be considered as covered services by the Plan only from a licensed hospital or a licensed freestanding ambulatory surgical center.


17. **Laboratory Tests** – must be ordered by a physician.
18.  **Manipulative Therapy** – chiropractic or osteopathic manipulation used to treat neuromuscular and/or musculoskeletal conditions on a short-term basis when the potential for functional gains exists.
19. **Nurse Practitioners** – Medically necessary services provided in a hospital, clinic, professional office, home care setting, long-term care setting or any other setting when services are provided by a nurse practitioner who is practicing within the scope of his/her license.
20.  **Occupational Therapy** – by a registered occupational therapist when ordered by a physician

 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care Program section for specific notification requirements and responsibilities.






## Description of Covered Services

21. **Orthotics** – covered when they meet the following criteria:
- (a) ordered by a physician
  - (b) custom fabricated (molded and fitted) to the patient's body
  - (c) for use by that patient only
22.  **Oxygen** and its administration.
23.  **Physical Therapy** – physical therapy used to treat neuromuscular and/or musculoskeletal conditions on a short-term basis when the potential for functional gain exists. The Plan only covers one-on-one therapies rendered by a registered physical therapist or certified physical therapy assistant (under the direction of a physical therapist) and when ordered by a physician.
24. **Physician Services** – medically necessary services provided by a licensed physician acting within the scope of that license providing such services in the home, hospital, physician's office, or other medical facility. Charges by physicians for their availability in case their services may be needed are not covered services. The Plan only pays physicians for the actual delivery of medically necessary services. Any charges for telephone and e-mail consultations are not covered.
25. **Preventive Care Schedule:**
- (a) **For children (up to age 19)** – The Plan covers preventive level office visits or physical examinations for children as follows:
    - two examinations, including hearing screening, while the newborn is in the hospital;
    - every two months until 18 months of age; then
    - every three months from 18 months of age until 3 years of age; then
    - every 12 months from 3 years of age until 19 years of age.
  - (b) **For adults (age 19 and over)** – The Plan covers preventive or routine level office visits or physical examinations every 12 months.
  - (c) The following screening procedures and laboratory tests performed as a component of preventive care:
    - hemoglobin
    - urinalysis
    - glaucoma testing
    - flexible sigmoidoscopy (exam of the lower bowel)
    - chemistry profile for the purpose of preventive screening includes the following:
      - complete blood count (CBC)
      - glucose
      - blood urea nitrogen (BUN)
      - creatinine
      - transferase alanine amino (SGPT)
      - transferase aspartate amino (SGOT)
      - thyroid stimulating hormone (TSH)
  - (d) The following screening procedures and laboratory tests performed as indicated:
    - blood cholesterol level (every five years), including high density cholesterol (HDL) and low density cholesterol (LDL), in addition to total cholesterol
    - bone mineral density (BMD) testing of the hip or spine for screening purposes every two years for women over age 40. Peripheral BMD testing of the wrist, forearm, finger and/or heel is not covered as a preventive care benefit.
    - colonoscopy for routine screening (once every 10 years after age 50); however, virtual colonoscopy or virtual colonography is not covered (see Exclusions)
    - mammograms (once between the ages of 35 and 40; yearly after age 40)
    - stool for occult blood (annually after age 50)

 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care Program section for specific notification requirements and responsibilities.

## Description of Covered Services

- (e) Gynecological examination annually (every 12 months) for women, including Pap smear
- (f) Immunizations
26.  **Private Duty Nursing Care** – highly skilled nursing care needed continuously during a block of time (greater than two hours) provided by a registered nurse while you are confined to your home. Charges for a Licensed Practical Nurse (LPN) are provided as shown in the Benefit Highlights section. Private Duty Nursing Care must:
- (a) be medically necessary
  - (b) provide skilled nursing services, and
  - (c) be exclusive of all other home health care services
  - (d) not duplicate services that a hospital or facility is licensed to provide
27. **Prostheses** – replacement of such equipment is also covered when required due to pathological change or normal growth.
28. **Radioactive Isotope Therapy**
29. **Radiotherapy**
30. **Retail Medical Clinics** – charges for medically necessary services for episodic, urgent care such as treatment for an earache or sinus infection at licensed retail medical clinics located at certain pharmacies. Flu vaccines may also be administered at these clinics.
31. **Routine Eye Examinations (including refraction)** – covered once every 24 months
32. **Routine Foot Care** – charges for medically necessary routine foot care are covered if accompanied by medical evidence documenting:
- in the case of an ambulatory patient, an underlying condition causing vascular compromise, such as diabetes, or
  - in the case of a non-ambulatory patient, a condition that is likely to result in significant medical complications in the absence of such treatment.
33. **Speech-Language Pathology Services** – Expenses for the diagnosis and treatment of speech, hearing and language disorders are covered when provided by a licensed speech-language pathologist or audiologist when the services are provided in a hospital, clinic or private office. Services provided in a school-based setting are not covered.
- Covered speech-language pathology services include the following:
- the examination and remedial services for speech defects caused by physical disorders
  - physiotherapy in speech rehabilitation following laryngectomy
- The Plan does not cover the following:
- services that a school system is obligated to provide under Chapter 766 in Massachusetts or under a similar law in other states
  - language therapy for learning disabilities such as dyslexia
  - cognitive therapy or rehabilitation
  - voice therapy
34. **Wigs** – are covered for the replacement of hair loss as a result of treatment of any form of cancer or leukemia. The maximum benefit for a wig is limited to \$350 per calendar year.
35. **X-Rays** and other radiological exams.
-  **Transplant Services**
- Benefits are payable, subject to deductibles, coinsurance, copays and limitations, for necessary medical and surgical expenses incurred for the transplanting of a human organ. (To receive the maximum benefit, please refer to Quality Centers and Designated Hospitals for Transplants on page 26.)

 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care Program section for specific notification requirements and responsibilities.

## Description of Covered Services

### Human Organ Donor Services

Benefits are payable, subject to deductibles, coinsurance and limitations, for necessary expenses incurred for delivery of a human organ (any part of the human body, excluding blood and blood plasma) and medical expenses incurred by a person in direct connection with the donation of a human organ.

Benefits are payable for any person who donates a human organ to a person covered under the Plan, regardless of whether the donor is a member of the Plan.

The Plan also covers expenses for human leukocyte antigen testing or histocompatibility locus antigen testing necessary to establish the suitability of a bone marrow transplant donor. Such expenses consist of testing for A, B or DR antigens, or any combination thereof, consistent with the guidelines, criteria, rules and regulations established by the Massachusetts Department of Public Health.

### Hospice Care Services

Upon certification by a physician that the covered individual is terminally ill, benefits are payable for charges incurred for the covered hospice care services when the patient is enrolled in a Medicare-certified hospice program. The services must be furnished under a written plan of hospice care, established by a hospice and periodically reviewed by the medical director and interdisciplinary team of the hospice.

A person is considered to be terminally ill when given a medical prognosis of six (6) months or less to live.

#### List of Covered Hospice Care Services

The Plan covers the following hospice care services:

1. Part-time, intermittent nursing care provided by or supervised by a registered nurse
2. Physical, respiratory, occupational and speech therapy by an appropriate licensed or certified therapist

3. Medical social services
4. Part-time, intermittent services of a home health aide under the direction of a registered nurse
5. Necessary medical supplies and medical appliances
6. Drugs and medications prescribed by a physician and charged by the hospice
7. Laboratory services
8. Physicians' services
9. Transportation needed to safely transport the terminally ill person to the place where that person is to receive a covered hospice care service
10. Psychological, social and spiritual counseling for the patient furnished by a:
  - (a) physician
  - (b) psychologist
  - (c) member of the clergy
  - (d) registered nurse, or
  - (e) social worker
11. Dietary counseling furnished by a registered dietitian
12. Respite care
13. Bereavement counseling furnished to surviving members of a terminally ill person's immediate family or other persons specifically named by a terminally ill person. Bereavement counseling must be furnished within 12 months after the date of death and it must be furnished by a:
  - (a) physician
  - (b) psychologist
  - (c) member of the clergy
  - (d) registered nurse, or
  - (e) social worker

No hospice benefits are payable for services not included in the List of Covered Hospice Care Services, nor for any service furnished by a volunteer or for which no charge is customarily made.



To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care Program section for specific notification requirements and responsibilities.

## Description of Covered Services

### Hospital-Based Personal Emergency Response Systems (PERS)

Benefits are payable for the rental of a PERS if:

1. the service is provided by a hospital
2. the patient is homebound and at risk medically, and
3. the patient is alone at least four (4) hours a day, five (5) days a week, and is functionally impaired

No benefits are payable for the purchase of a PERS unit.

### Durable Medical Equipment (DME)

To meet the Plan's definition of DME, the service or supply must be:

1. provided by a DME supplier
2. designed primarily for therapeutic purposes or to improve physical function
3. provided in connection with the treatment of disease, injury or pregnancy upon the recommendation and approval of a physician
4. able to withstand repeated use, and
5. ordered by a physician


Benefits are payable if the DME service or supply meets the Plan's definition of DME and is determined to be medically necessary, except as described in the Exclusions section of this Handbook.

The Plan covers the rental of DME up to the purchase price. If the Plan determines that the purchase cost is less than the total expected rental charges, it may decide to purchase such equipment for your use. If you choose to continue to rent the equipment, the Plan will not cover rental charges that exceed the purchase price.

### Excluded Items

No benefits are available for personal comfort items such as, but not limited to, air conditioners, air purifiers, arch supports, bed pans, blood pressure monitors, commodes, corrective shoes, dehumidifiers, dentures, elevators, exercise equipment, heating pads, hot water bottles, humidifiers, shower chairs, whirlpools or spas. These items do not qualify as covered durable medical equipment.

**Important:** Using Preferred Vendors will maximize your benefit by reducing your out-of-pocket cost.


 Visit our web site at [www.unicarestateplan.com](http://www.unicarestateplan.com) for a list of Preferred Vendors for durable medical equipment, or call the Andover Service Center at (800) 442-9300.

### Coverage for Clinical Trials

Patient care services provided as part of a qualified clinical trial are covered to the same extent as they would be covered if the patient did not receive care in a qualified clinical trial. Coverage is subject to all other provisions of the Plan including, but not limited to, provisions relating to the use of participating providers and utilization review.

“Patient care service” means a health care item or service provided to an individual enrolled in a qualified clinical trial that is consistent with the patient's diagnosis, consistent with the study protocol for the clinical trial and would be covered if the patient were not a participant in a clinical trial. “Patient care service” does not include:

1. An investigational drug or device. However, a drug or device that has been approved for use in the qualified clinical trial will be a patient care service to the extent that the drug or device is not paid for by the manufacturer, distributor or provider of the drug or device, regardless of whether the Food and Drug Administration has approved the drug or device for use in treating the patient's particular condition.

 To obtain the maximum level of benefits, you or your provider must notify the Andover Service Center at (800) 442-9300. See the Managed Care Program section for specific notification requirements and responsibilities.

## Description of Covered Services

2. Non-health care services that a patient may be required to receive as a result of participation in the clinical trial
3. Costs associated with managing the research of the clinical trial
4. Costs that would not be covered for non-investigational treatments
5. Any item, service or cost that is reimbursed or furnished by the sponsor of the clinical trial
6. The costs of services that are inconsistent with widely accepted and established national or regional standards of care
7. The costs of services that are provided primarily to meet the needs of the trial, including, but not limited to, tests, measurements and other services that are typically covered but are being provided at a greater frequency, intensity or duration
8. Services or costs that are not covered under the Plan

## Exclusions

The PLUS Plan does not provide benefits for the following services. Please note that charges that are excluded by the Plan do not count toward out-of-pocket maximums and deductible amounts.


1. A service or supply furnished without the recommendation and approval of a physician (that is, without an order).
2. A service or supply reviewed under the Managed Care Program and determined by the Plan not to be medically necessary.
3. A service or supply that is determined by the Plan to be experimental or investigational; that is, inadequate or lacking in evidence as to its effectiveness, through the use of objective methods and study over a long enough period of time to be able to assess outcomes. The fact that a physician ordered it, or that this treatment has been tried after others have failed, does not make it medically necessary.
4. A service or supply that is not medically necessary for the care and treatment of an injury, disease or pregnancy, unless:
  - (a) furnished by a hospital for routine care of a child during a hospital stay that begins with birth and while the child's mother is confined in the same hospital; or
  - (b) furnished by a hospital or physician for covered preventive care, as described under Description of Covered Services on pages 42–43; or
  - (c) such service or supply qualifies as a covered Hospice Care service (see page 44)
5. A service or supply furnished for an occupational injury or disease for which a person is entitled to benefits under a Workers' Compensation Law or similar law.
6. A service or supply provided by you, a member of your family or by any person who resides in your home. Your family consists of you, your spouse and children, as well as brothers, sisters and parents of both you and your spouse.
7. A medical supply or service (such as a court-ordered testing or an insurance physical) required by a third party that is not otherwise medically necessary. Examples of a third party are an employer, an insurance company, a school or a court.
8. Acne-related services, such as the removal of acne cysts, injections to raise acne scars, cosmetic surgery, dermabrasion or other procedures to plane the skin. Benefits are provided for outpatient medical care to diagnose or treat the underlying condition identified as causing the acne.
9. Acupuncture and acupuncture-related services
10. Anesthesia and other services required for the performance of a service that is not covered under the Plan. Non-covered services include those for which there is no Plan benefit and those that the Plan has determined to be not medically necessary.
11. Arch supports
12. The amount by which a charge for blood is reduced by blood donations
13. Blood pressure cuff (sphygmomanometer)
14. Breast pumps
15. Transportation in chair cars/vans
16. Cognitive rehabilitation or therapy
17. Computer-assisted communication devices
18. Custodial care
19. Dentures or dental prostheses



## Exclusions

20. Services related to surgery undertaken as the result of denture wear or to prepare for the fitting of new dentures
21. Dietary or nutritional counseling or services provided by a dietitian or nutritional counselor except for services performed by a registered dietician for members with diabetes (see page 40 for details)
22. Drugs not used in accordance with indications approved by the Food and Drug Administration (off label use of a prescription drug), unless the use meets the definition of medically necessary as determined by the Plan or the drug is specifically designated as covered by the Plan
23. Over-the-counter drugs
24. Any services or supplies furnished by, or covered as a benefit under, a program of any government or its subdivisions or agencies except for the following:
  - (a) a program established for its civilian employees
  - (b) Medicare (Title XVIII of the Social Security Act)
  - (c) Medicaid (any state medical assistance program under Title XIX of the Social Security Act)
  - (d) a program of hospice care
25. Hearing aid batteries or ear molds
26. Hippotherapy
27. Incontinence supplies
28. Experimental treatment for infertility
29. Internet providers or e-mail consultations
30. Language therapy for learning disabilities such as dyslexia
31. Lift or riser chairs
32. Long-term maintenance care or long-term therapy
33. Certain manipulative or physical therapy services, including but not limited to: paraffin treatment; microwave, infrared and ultraviolet therapies; diathermy; massage therapy; acupuncture; aerobic exercise; rolfing therapy; Shiatsu; sports conditioning/weight training; craniosacral therapy; kinetic therapy; or therapies performed in a group setting
34. Massage therapy or services provided by a massage therapist or neuromuscular therapist
35. A medical service or supply for which a charge would not have been made in the absence of medical insurance
36. Any medical services, including in vitro fertilization, in connection with the use of a gestational carrier or surrogate
37. Benefits for the diagnosis, treatment or management of mental health/substance abuse conditions by medical (non-mental health) providers. These benefits are covered when provided by mental health providers (see United Behavioral Health section for coverage details).
38. Molding helmets and adjustable bands intended to mold the shape of the cranium
39. Orthodontic treatment, including treatment done in preparation for surgery
40. Orthopedic/corrective shoe(s), except when the shoe(s) attaches directly to a brace
41. Orthopedic mattresses
42. Oxygen equipment required for use on an airplane or other means of travel
43. Personal comfort items that could be purchased without a prescription, such as air conditioners, air purifiers, bed pans, blood pressure monitors, commodes, dehumidifiers, elevators, exercise equipment, heating pads, hot water bottles, humidifiers, shower chairs, telephones, televisions, whirlpools or spas and other similar items

## Exclusions

44. Any physical therapy services provided by athletic trainers
45. Private duty nursing services in an acute care hospital or any other inpatient facility
46. Redundant or duplicate services. A service or supply is considered redundant when the same service or supply is being provided or being used, concurrently, to treat the condition for which it is ordered.
47. Services received at non-medical religious facilities
48. Reversal of voluntary sterilization
49. Sensory integration therapy
50. Any services and treatments required under law to be provided by the school system for a child
51. Costs associated with serious preventable adverse health care events are not covered, in accordance with Department of Public Health (DPH) regulations. Massachusetts providers are not permitted to bill members for designated serious reportable health care events.  For more information on this policy and a list of these events, visit [www.unicarestateplan.com](http://www.unicarestateplan.com) and click on “Forms and Documents” under the “Members” tab.
52. Sexual reassignment surgery and related services
53. Smoking cessation programs or medications
54. Stairway lifts and stair ramps
55. Storage of autologous blood donations or other bodily fluids or specimens, except when done in conjunction with use in a scheduled procedure that is covered under the Plan
56. Surface electromyography (SEMG)
57. Telephone consultations
58. Any type of thermal therapy device
59. Virtual colonoscopy or virtual colonography (standard colonoscopy, however, is covered)
60. Vision care, including:
  - (a) orthoptics or visual therapy for correction of vision
  - (b) radial keratotomy and related laser surgeries
  - (c) other surgeries, services or supplies furnished in conjunction with the determination or correction of refractive errors such as astigmatism, myopia, hyperopia and presbyopia (except as shown under Routine Eye Examinations in the Benefit Highlights and Covered Services sections)
61. Voice therapy
62. Worksite evaluations performed by a physical therapist to evaluate a patient’s ability to return to work

## Limitations

The PLUS Plan limits benefits for the following services and products:

1. **Ambulance** used for transportation services other than in the case of an emergency. Please see the definition of “Emergency” on page 54. Benefits are payable only for transportation to the nearest facility equipped to treat the condition. Transportation required for medical appointments, including dialysis treatment, is not covered.
2. **Air and sea ambulance services** are limited to the medically necessary transfer to the nearest facility equipped to treat the condition.
3. **Assistant surgeon services** are limited to the services of only one assistant surgeon per procedure when medically necessary. Second and third assistants are not covered.  
  
Non-physician assistants at surgery, such as physician assistants (PAs), nurse practitioners, nurses and technicians are not covered. Interns, residents and fellows are also not covered. Chiropractors, dentists, optometrists and certified midwives are not covered as surgical assistants or as assistant surgeons.
4. **Bone density testing** is not covered when done solely for the purpose of screening or prevention, except as described in Item 25 (d) (Preventive Care Schedule) in the Description of Covered Services section. Peripheral bone mineral density testing of the wrist, forearm, finger and/or heel is not covered as a preventive care benefit.
5. **Cosmetic procedures/services** are not covered, with the exception of the initial surgical procedure to correct appearance that has been damaged by an accidental injury.

6. **Dental benefits** are limited. The PLUS Plan is a medical plan, not a dental plan. The PLUS Plan provides benefits for covered services relating to dental care or surgery in the following situations only:

- (a) Emergency treatment rendered by a dentist within 72 hours of an accidental injury to the mouth and sound natural teeth. This treatment is limited to the initial first aid (trauma care), reduction of swelling, pain relief, covered non-dental surgery and non-dental diagnostic x-rays.
- (b) Oral surgical procedures for non-dental medical treatment, such as the reduction of a dislocated or fractured jaw or facial bone, and removal or excision of benign or malignant tumors, are provided to the same extent as other covered surgical procedures described on page 58.
- (c) The following procedures when a member has a serious medical condition\* that makes it essential that he or she be admitted to a hospital as an inpatient, or to a surgical day care unit or ambulatory surgical facility as an outpatient, in order for the dental care to be performed safely:
  - (1) extraction of seven (7) or more teeth
  - (2) gingivectomies (including osseous surgery) of two (2) or more gum quadrants
  - (3) excision of radicular cysts involving the roots of three (3) or more teeth
  - (4) removal of one (1) or more impacted teeth

Facility, anesthesia and related charges are only covered when the dental treatment or services are covered under the Plan.

Dentures or dental prostheses, and the surgery in preparation for dentures, are not covered under the Plan.

\* *Serious medical conditions include, but are not limited to, hemophilia and heart disease.*

## Limitations

7. **Electrocardiograms** (EKGs) are not covered when done solely for the purpose of screening or prevention.
8. **Eyeglasses/contact lenses** are limited to the provision, replacement or fitting for the initial set only when subsequent to an injury to the eye or up to six (6) months following cataract surgery.
9. **In Vitro Fertilization** and other associated infertility procedures, with the exception of artificial insemination, are limited to five (5) attempts (see definition of “Attempt” on page 52).
10. **Orthotics** are limited to medically necessary devices. Charges for test or temporary orthotics are not covered. Charges for video tape gait analysis and diagnostic scanning are not covered. Arch supports are also not covered.
11. **Prostate-Specific Antigen (PSA) Test** is covered only if ordered by a physician in conjunction with the treatment of a medical condition.
12. **Respite Care** is limited to a total of five days for a hospice patient in order to relieve the family or the primary care person from caregiving functions. Respite care is covered in a hospital, a skilled nursing facility, a nursing home or in the home.
13. **Retail Medical Clinics** are limited to providing care within the scope of their license in the state in which they are providing services.
14. **Routine screening** is not covered other than the Preventive Care Services specified in the Description of Covered Charges on pages 42–43.
15. **Treatment of Temporomandibular Joint (TMJ) disorder** is limited to the initial diagnostic examination, initial testing and medically necessary surgery.
16. **Weight loss programs** are limited to the treatment of members whose body mass index (BMI) is 40 or more (morbidly obese) while under the care of a physician. Any such program is subject to periodic review for medical necessity and progress.
17. **Wigs** are limited to the replacement of hair loss as a result of treatment of any form of cancer or leukemia. The maximum benefit for a wig is limited to \$350 per calendar year.

## Plan Definitions

Some terms used in the UniCare State Indemnity Plan/PLUS Handbook are defined below as they relate to your benefits. Read these definitions carefully; they will help you understand what is covered under the Plan.

**“Acute Care”** – a level of care required as a result of the sudden onset or worsening of a condition that necessitates short term, intensive medical treatment. Acute inpatient care must be provided at a facility licensed as an acute care hospital. See definition for “Hospital.”

**“Ancillary Services”** – the services and supplies that a facility ordinarily renders to its patients for diagnosis or treatment during the time the patient is in the facility. Ancillary Services include such things as:

1. use of special rooms, such as operating or treatment rooms
2. tests and exams
3. use of special equipment in the facility
4. drugs, medications, solutions, biological preparations and medical and surgical supplies used while an inpatient in the facility
5. administration of infusions and transfusions. This does not include the cost of whole blood, packed red cells, or blood donor fees.
6. devices that are an integral part of a surgical procedure. This includes items such as hip joints, skull plates and pacemakers. It does not include devices that are not directly involved in the surgery, such as artificial limbs, artificial eyes or hearing aids.

**“Assistant Surgeon”** – a physician trained in the appropriate surgical specialty who serves as the first assistant to another surgeon during a surgical procedure. When medically appropriate, the service of only one assistant per procedure is covered under the Plan.

**“Attempt”** – the initiation of a reproductive cycle with the expectation of implanting a fertilized ovum. The occurrence of either of the following events constitutes an attempt:

- commencement of drug therapy to induce ovulation; or
- operative procedures for the purpose of implantation of a fertilized ovum.

**“Cardiac Rehabilitation Program”** – a recognized, multi-disciplinary program operated by a licensed facility that treats cardiovascular disease through cardiac rehabilitation treatment. The program must meet the generally accepted standards of cardiac rehabilitation.

**“Cardiac Rehabilitation Treatment”** – treatment of documented cardiovascular disease by a cardiovascular rehabilitation program that includes exercise and diet management to improve cardiovascular function.

**“Cognitive Rehabilitation or Cognitive Therapy”** – treatment to restore function or minimize effects of cognitive deficits, including but not limited to those related to thinking, learning and memory.

**“Complex Inpatient Procedures and High-Risk Deliveries and Neonatal ICUs”** – select inpatient surgical procedures designated by the Plan or high-risk deliveries for which significant clinical experience is likely to enhance the quality of care. The Plan has also specified certain hospitals that meet experience parameters in terms of patient volume for each of these procedures. For those procedures performed in the corresponding specified hospitals, services are covered at the lower member deductibles and copays.

**“Coronary Artery Disease Secondary Prevention Program”** – an approved established program for individuals with a diagnosis of coronary artery disease, offered by a specialized interdisciplinary team of clinicians, designed to reduce the effects of heart disease by lifestyle change, diet control, exercise, stress reduction and group support.

## Plan Definitions

**“Cosmetic Procedures/Services”** – Cosmetic services are those services performed mainly for the purpose of improving appearance. These services do not restore bodily function or correct functional impairment. Cosmetic services are not covered, even if they are intended to improve a member’s emotional outlook or treat a member’s mental health condition.

**“Custodial Care”** – a level of care that is chiefly designed to assist a person in the activities of daily living and cannot reasonably be expected to greatly restore health or bodily function.

**“Dependent”** –

1. The legal spouse (or the former spouse if authorized by the GIC) of the covered employee or retiree
2. The child of a covered employee, retiree or surviving spouse by birth, legal adoption (upon placement of the child in the home), under custody pursuant to a court order, or under legal guardianship until the age of 19 years
3. A child who depends upon and lives with the covered employee, retiree or surviving spouse and for whom there is evidence of a regular parent-child relationship satisfactory to the GIC, until the age of 19 years
4. An unmarried child who upon becoming 19 years of age is mentally or physically incapable of earning his or her own living, proof of which must be on file with the GIC
5. A dependent age 19 or over, but under age 26, who qualifies as a dependent under the Internal Revenue Code
6. A dependent age 19 or over until the earlier of two years following the loss of dependent status under the Internal Revenue Code or age 26, whichever comes first

7. A full-time student, as determined by the GIC, until age 26. At age 26, a full-time student may elect to continue coverage as an individual under the UniCare State Indemnity Plan and pay 100% of the required premium. That student must file a written application with the GIC, and the application must be approved by the GIC, or
8. A newborn child of a covered employee’s, retiree’s or surviving spouse’s dependent son or daughter until the parent of such child ceases to be a dependent of such covered person, or the date the newborn child ceases to be a dependent, whichever occurs first.

**“Designated Hospital”** – a hospital designated by the Plan for which the benefits are covered at a higher level for certain services, specifically: complex procedures, high-risk deliveries, neonatal ICUs and transplants.

**“Durable Medical Equipment”** – equipment designed primarily for therapeutic purposes or to extend function that can stand repeated use and is medically necessary and prescribed by a physician. Such equipment includes wheelchairs, crutches, oxygen and respiratory equipment. Personal items related to activities of daily living such as commodes and shower chairs are not covered.

**“Early Intervention Services”** – medically necessary services that include occupational, physical and speech therapy, nursing care and psychological counseling for children from birth until their third birthdays. These services must be provided by persons licensed or certified under Massachusetts law, who are working in Early Intervention programs approved by the Department of Public Health.



## Plan Definitions

**“Emergency”** – An emergency is an illness or medical condition, whether physical or mental, that manifests itself by symptoms of sufficient severity, including severe pain that in the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in serious jeopardy to physical and/or mental health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or, in the case of pregnancy, a threat to the safety of a member or her unborn child. Emergency treatment does not include Urgent Care. Emergency treatment may be rendered in a hospital, physician’s office or other medical facility.

**“Enrollee”** – an employee, retiree or survivor covered by the GIC’s health benefits program who is enrolled in the Plan.

**“Enteral Therapy”** – prescribed nutrition that is administered through a tube that has been inserted into the stomach or intestines. Enteral formulas are not covered under the medical plan. Prescription and nonprescription enteral formulas are covered under the prescription drug plan only when ordered by a physician for the medically necessary treatment of malabsorption disorders caused by Crohn’s disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

**“Experimental or Investigational Procedure”** – a service that is determined by the Plan to be experimental or investigational; that is, inadequate or lacking in evidence as to its effectiveness, through the use of objective methods and study over a long enough period of time to be able to assess outcomes. The fact that a physician ordered it or that this treatment has been tried after others have failed does not make it medically necessary.

**“Family Planning Services”** – office visits and procedures for the purpose of contraception. Procedures include fitting for a diaphragm or cervical cap; the insertion, re-insertion, or removal of an IUD or Levonorgestrel (Norplant); and the injection of progesterone (Depo-Provera). FDA-approved contraceptive drugs and devices are available through your prescription drug plan.

**“High-Tech Imaging Services”** – Applies to tests that are sometimes referred to as “advanced radiology procedures.” These tests vary from plain film x-rays by offering providers a more comprehensive view of the human body. Many of these tests also subject members to significantly higher levels of radiation compared to plain film x-rays and are also much more expensive. These procedures include but are not limited to MRIs, CT scans and PET scans.

**“Home Health Care”** – health services and supplies provided by a home health care agency on a part-time, intermittent or visiting basis. Such services and supplies must be provided in a person’s place of residence (not an institution) while the person is confined as a result of injury, disease or pregnancy. To be considered for coverage, Home Health Care must be delivered by a Home Health Care Agency certified by Medicare.

**“Home Health Care Plan”** – a plan of care for services in the home ordered in writing by a physician. A Home Health Care Plan is subject to review and approval by the Plan.

**“Home Infusion Company”** – a company that is licensed as a pharmacy and is qualified to provide home infusion therapy.

**“Home Infusion Therapy”** – the administration of intravenous, subcutaneous or intramuscular therapies provided in the home setting. Subcutaneous and intramuscular drugs are available through your prescription drug plan.

## Plan Definitions

**“Hospice”** – a public agency or a private organization that provides care and services for terminally ill persons and their families and is certified as such by Medicare.

**“Hospital”** – an institution that meets all of the following conditions:

1. is operated pursuant to law for the provision of medical care
2. provides continuous 24-hour-a-day nursing care
3. has facilities for diagnosis
4. has facilities for major surgery
5. provides acute medical/surgical care or acute rehabilitation or care
6. is licensed as an acute hospital, and
7. has an average length of stay of less than 25 days

The term “Hospital” includes freestanding ambulatory surgical centers operating pursuant to law.

The term “Hospital” does not include:

- (a) rest homes
- (b) nursing homes
- (c) convalescent homes
- (d) places for custodial care
- (e) homes for the aged

Also see definition for “Other Inpatient Facilities.”

**“Hospital Stay”** – the time a person is confined to a hospital and incurs a room and board charge for inpatient care other than custodial care.

**“Incurred Date”** – the date a service or supply is provided.

**“Infertility”** – the condition of a healthy individual who is unable to conceive or produce conception during a period of one year, except if this condition is the result of voluntary sterilization or the normally occurring aging process.

**“Injury”** – bodily injury sustained accidentally by external means.

**“Manipulative Therapy”** – hands-on treatment provided by a chiropractor, osteopath or physician by means of direct manipulation or movement to relieve pain, restore function and/or minimize disability as a result of disease or injury to the neuromuscular and/or musculoskeletal system. See Exclusions 33 and 34 in the Exclusions section for examples of manipulative therapies that are not covered.

**“Medically Necessary”** – with respect to care under the Plan, means that the treatment will meet at least the following standards:

1. is adequate and essential for evaluation or treatment consistent with the symptoms, proper diagnosis and treatment appropriate for the specific member’s illness, disease or condition as defined by standard diagnostic nomenclatures (DSM-IV or its equivalent ICD-9CM)
2. is reasonably expected to improve or palliate the member’s illness, condition or level of functioning
3. is safe and effective according to nationally accepted standard clinical evidence generally recognized by medical professionals and peer-reviewed publications
4. is the most appropriate and cost-effective level of care that can safely be provided for the specific member’s diagnosed condition, and
5. is based on scientific evidence for services and interventions that are not in wide-spread use

**Note:** The fact that a physician may prescribe, order, recommend or approve a procedure, treatment, facility, supply, device or drug does not, in and of itself, make it “Medically Necessary” or make the charge a covered expense under the Plan, even if it has not been listed as an exclusion.

**“Medical Supplies or Equipment”** – disposable items prescribed by physicians as medically necessary to treat disease and injury. Such items include surgical dressings, splints, and braces.

## Plan Definitions

**“Member”** – an enrollee or his/her dependent who is enrolled in the Plan.

**“Non-Experimental Infertility Procedure”** – a procedure recognized as generally accepted and/or non-experimental by the American Fertility Society and the American College of Obstetrics and Gynecology.

**“Nursing Home”** – an institution that:

1. provides inpatient skilled nursing care and related services; and
2. is licensed in any jurisdiction requiring such licensing; but
3. does not qualify as a Skilled Nursing Facility (SNF) as defined by Medicare.

A home, facility or part of a facility does not qualify as a SNF or nursing home if it is used primarily for:

1. rest
2. the care of drug abuse or alcoholism
3. the care of mental diseases or disorders
4. custodial or educational care

**“Occupational Injury/Disease”** – an injury or disease that arises out of and in the course of employment for wage or profit (see Exclusions on page 47).

**“Occupational Therapy”** – Occupational therapy is skilled treatment that helps individuals achieve independence with activities of daily living after an illness or injury not incurred during the course of employment. Services include: treatment programs aimed at improving the ability to carry out activities of daily living; comprehensive evaluations of the home; and recommendations and training in the use of adaptive equipment to replace lost function.

**“Off Label Use of a Prescription Drug”** – the use of a drug that does not meet the prescribed indications as approved by the Food and Drug Administration (FDA).

**“Orthotic”** – an orthopedic appliance or apparatus used to support, align or correct deformities and/or to improve the function of movable parts of the body. An orthotic must be ordered by a physician, be custom fabricated (molded and fitted) to the patient’s body, and be for use by that patient only.

**“Other Inpatient Facilities”** – includes the following hospitals/facilities:

1. skilled nursing facilities
2. chronic disease hospitals/facilities
3. transitional care hospitals/facilities
4. sub-acute care hospitals/facilities
5. long-term care hospitals/facilities
6. any inpatient facility with an average length of stay greater than 25 days

**“Physical Therapy”** – hands-on treatment provided by a licensed physical therapist by means of direct manipulation, exercise, movement or other physical modalities to relieve pain, restore function and/or minimize disability as a result of disease or injury to the neuromuscular and/or musculoskeletal system or following the loss of a body part. For examples of non-covered physical therapy services, see Exclusions 33 and 34 in the Exclusion section.

**“Physician”** – the term “physician” includes the following health care providers acting within the scope of their licenses or certifications:

1. physician
2. certified nurse midwife
3. chiropractor
4. dentist
5. nurse practitioner
6. optometrist
7. podiatrist

**“Physician Tiering”** – a program implemented by the Plan as part of the GIC’s Clinical Performance Improvement (CPI) Initiative, whereby Massachusetts physicians are assigned to different tiers based on an extensive evaluation of both their quality and cost-efficiency.

## Plan Definitions

**“PLUS Provider”** – includes all physicians, hospitals and covered health care providers (except for non-Preferred Vendors) in Massachusetts, and UniCare network providers outside Massachusetts. PLUS providers include Preferred Vendors listed online at [www.unicarestateplan.com](http://www.unicarestateplan.com) (see definition for Preferred Vendor in this section).

**“Preferred Vendor”** – a provider contracted by the Plan to provide certain services or equipment, including but not limited to durable medical equipment and home health care. When you use these Preferred Vendors, you receive these services at a higher benefit level than when you use other providers for these services.

**“Prostheses”** – items that replace all or part of a bodily organ or limb and that are medically necessary and are prescribed by a physician. Examples include breast prostheses and artificial limbs.

**“Reasonable and Customary Allowed Amount”** – The Reasonable and Customary Allowed Amount (also referred to as the allowed amount) is the amount UniCare determines to be within the range of payments most often made to similar providers for the same service or supply. This allowed amount may not be the same as the provider’s actual charge. These allowed amounts are expressed as maximum fees in fee schedules, maximum daily rates, flat amounts or discounts from charges.

**“Reasonable and Customary Charge”** – a charge that does not exceed the general level of charges being made by others in a given geographic area where the charge is incurred when furnishing like or similar treatment, services or supplies.

**“Reconstructive and Restorative Surgery”** – surgery intended to improve or restore bodily function or to correct a functional physical impairment that has been caused by one of the following:

- a congenital anomaly, or
- a previous surgical procedure or disease

Restoration of a bodily organ that is surgically removed during treatment of cancer must be performed within five (5) years of surgical removal.

**“Respite Care”** – services rendered to a hospice patient in order to relieve the family or primary care person from caregiving functions.

**“Retail Medical Clinics”** – Licensed medical clinics located at certain pharmacies that provide services by nurse practitioners or physician assistants for basic primary medical services. These services are limited to episodic, urgent care such as treatment for an earache or sinus infection. Retail medical clinics are limited to providing care within the scope of their license in the state in which they are providing services.

**“Skilled Care”** – medical services that can only be provided by a registered or certified professional health care provider.

**“Skilled Nursing Facility (SNF)”** – an institution that:

1. is operated pursuant to law
2. is licensed or accredited as a skilled nursing facility if the laws of the jurisdiction in which it is located provide for the licensing or the accreditation of a skilled nursing facility
3. is approved as a skilled nursing facility for payment of Medicare benefits or is qualified to receive such approval, if requested
4. is primarily engaged in providing room and board and skilled nursing care under the supervision of a physician
5. provides continuous 24-hour-a-day skilled nursing care by or under the supervision of a registered nurse (RN), and
6. maintains a daily medical record of each patient

A home, facility or part of a facility does not qualify as a skilled nursing facility or nursing home if it is used primarily for:

1. rest
2. the care of mental diseases or disorders
3. the care of drug abuse or alcoholism, or
4. custodial or educational care

## Plan Definitions

**“Spouse”** – the legal spouse of the covered employee or retiree.

**“Surgical Procedure”** – any of the following types of treatment:

1. a cutting procedure
2. the suturing of a wound
3. the treatment of a fracture
4. the reduction of a dislocation
5. radiotherapy, excluding radioactive isotope therapy, if used in lieu of a cutting operation for removal of a tumor
6. electrocauterization
7. diagnostic and therapeutic endoscopic procedures
8. injection treatment of hemorrhoids and varicose veins, and
9. an operation by means of laser beam

**“Temporomandibular Joint (TMJ) Disorder”** – a syndrome or dysfunction of the joint between the jawbone and skull and the muscles, nerves and other tissues related to that joint.

**“Terminal Illness”** – an illness that, if it runs its course, is associated with a life expectancy of six months or less.

**“Tiers”** – different levels into which the Plan groups physicians and hospitals based upon an evaluation of certain quality measures and how efficiently they use their resources.

**“Travel Access Providers”** – UniCare providers that are available to members when traveling outside their home state. When you use these providers, you are not balance billed for your care.

**“Urgent Care”** – treatment that is provided as soon as the treatment can be arranged, but the treatment is not immediately necessary to prevent death or permanent impairment. Urgent Care does not qualify as emergency treatment.

**“Visiting Nurse Association”** – an agency certified by Medicare that provides part-time, intermittent skilled nursing services and other home care services in a person’s place of residence and is licensed in any jurisdiction requiring such licensing.

**“Written Proof”** – satisfactory proof, in writing, of the incurral of a claim.

## General Provisions

This section describes the enrollment process for you and your eligible dependent(s); when coverage begins and ends; and continuing coverage when eligibility status changes.

### Application for Coverage

You must apply to the GIC for enrollment in the Plan. To obtain the appropriate forms, active employees should contact their GIC Coordinator, and retirees should contact the GIC.

**To enroll newborns:** You must enroll a child within 31 days of the child's birth. Active employees should see their GIC Coordinator to add the child to their health insurance coverage. Retirees must submit a written request for coverage to the GIC and include a copy of the child's birth certificate.

**To enroll or add your dependent(s):** You must enroll each additional dependent when he or she becomes eligible. If you marry, you must enroll your spouse within 31 days of the marriage.

**To enroll adopted children:** Adopted children must be enrolled within 31 days of placement in the home. Send a written request to the GIC along with a letter from the adoption agency that states the date the child was placed in the home.

**Continued dependent coverage:** A dependent child who reaches age 19 is no longer automatically eligible for coverage under this Plan. In order to continue coverage for a dependent age 19 and over, you must complete all of the following steps:

1. Complete the written application that the GIC will send you prior to the dependent's 19th birthday;
2. Complete subsequent eligibility recertification forms; and
3. Return all of the completed forms as instructed by the GIC. If the forms are returned late, your dependent may have a gap in coverage.

The following types of dependents age 19 and over are eligible for coverage:

- **Student Dependents:** Coverage is available under a family plan for a child who is a full-time student at the age of 19 and enrolled in an accredited educational institution. Members must apply to the GIC for student dependent coverage. The GIC requires verification of full-time student status for any member enrolled as a student dependent under a family plan.
- **Full-time students age 26 and over:** A full-time student at an accredited educational institution at age 26 or over may elect to continue coverage as an individual member under the Plan at 100% of the required premium. That student must file a written application with the GIC and the application must be approved by the GIC.
- **A dependent age 19 or over but under age 26 who is a dependent under the Internal Revenue Code** is eligible for coverage under this Plan.
- **A dependent age 19 or over until the earlier of two years following the loss of dependent status under the Internal Revenue Code or age 26** is eligible for coverage under this Plan.

**Note:** Failure to recertify coverage when required will result in termination of continued dependent coverage. See "When Coverage Ends for Dependents" on page 60 for more information.



## General Provisions

### When Coverage Begins

Coverage under the Plan starts as follows:

**For new employees:** Coverage begins on the first of the month following 60 days or two calendar months of employment, whichever is less.

**For persons applying during an annual enrollment period:** Coverage begins on the following July 1.

**For dependents:** Coverage begins on the later of:

1. the date your own coverage begins, or
2. the date the person qualifies as your dependent

**For new retirees, spouses and surviving spouses:**  
You will be notified by the GIC of the date on which coverage begins.

### Continued Coverage

Your eligibility for these benefits continues if you are:

1. an employee of the Commonwealth, a municipality or other entity that participates in the GIC
2. a retiree of the Commonwealth, a municipality or other entity that participates in the GIC who is not eligible for Medicare
3. a surviving spouse who is not eligible for Medicare
4. a retiree with Medicare who is not eligible for the UniCare State Indemnity Plan/ Medicare Extension
5. the spouse of a retiree of the Commonwealth, a municipality or other entity that participates in the GIC who is enrolled in Medicare Parts A and B but you are not eligible for Parts A and B in your own right

### When Coverage Ends for Enrollees

Your coverage ends on the earliest of:

1. the end of the month covered by the last contribution toward the cost of your coverage
2. the end of the month in which you cease to be eligible for coverage
3. the date the enrollment period ends
4. the date of death
5. the date the survivor remarries, or
6. the date the UniCare State Indemnity Plan terminates

### When Coverage Ends for Dependents

A dependent's coverage ends on the earliest of:

1. the date your coverage under the UniCare State Indemnity Plan/PLUS ends
2. the end of the month covered by your last contribution toward the cost of such coverage
3. the date you become ineligible to have dependents covered
4. the date the enrollment period ends
5. the date the dependent ceases to qualify as a dependent
6. the date that the dependent child who is permanently and totally disabled and became so by age 19 marries and is no longer eligible for coverage as an IRS or non-IRS dependent
7. the date the dependent begins active duty in the armed forces of the United States
8. the date the divorced spouse remarries (or the date the enrollee marries, depending on the divorce decree)
9. the date of dependent's death, or
10. the date the UniCare State Indemnity Plan terminates

## General Provisions

### Duplicate Coverage

No person can be covered by any other GIC health plan at the same time as:

1. both an employee, retiree or surviving spouse and a dependent, or
2. a dependent of more than one covered person (employee, retiree, spouse or surviving spouse)

### Special Enrollment Condition

If you have declined the UniCare State Indemnity Plan for your spouse or for your dependent(s) because they have other health coverage, you may be able to enroll them during the Plan year if the other coverage is lost. To obtain the appropriate enrollment forms:

- Active Enrollees: check with your GIC Coordinator
- Retirees: contact the GIC

### Continuing Coverage

The following provisions in this section explain how coverage may be continued or converted if eligibility status changes.

#### Continuing Health Coverage Due to Involuntary Layoff

If you are no longer eligible for coverage due to involuntary layoff, you may have coverage under the UniCare State Indemnity Plan/PLUS continued for 39 consecutive weeks. This coverage would apply to you and all of your dependent(s) who are covered under the UniCare State Indemnity Plan at the time you are laid off.

In the event of involuntary layoff, the person who has the option to continue coverage must:

1. elect to continue coverage, in writing, within 30 days after the date eligibility for coverage ends, and
2. pay the full cost of the coverage to the GIC

Coverage will end on the earliest of:

1. the end of the month of 39 consecutive weeks following the date you cease to be eligible for coverage
2. the end of the month covered by the last contribution toward the cost of your coverage
3. the date the coverage ends
4. the date the UniCare State Indemnity Plan/PLUS terminates, or
5. in the case of a dependent, the date that dependent would cease to qualify as a dependent if you had remained eligible for the coverage

#### Option to Continue Coverage as a Deferred Retiree

You are eligible for deferred retirement if you:

1. have 10 or more years of full-time service (as determined by the State Retirement Board or your retirement board), and
2. are eligible for a pension from the State Retirement Board or your retirement board, and
3. are leaving your retirement monies in your retirement system

The person who chooses to continue health coverage as a deferred retiree must:

1. contact the GIC for enrollment information, and
2. pay the full cost of the coverage to the GIC

Coverage will end on the earlier of:

1. the end of the month covered by the last contribution toward the cost of your coverage
2. the date the coverage ends
3. the date the UniCare State Indemnity Plan terminates, or
4. in the case of a dependent, the date that dependent would cease to qualify as a dependent if you had remained eligible for the coverage
5. the date you withdraw your monies from the retirement system

## General Provisions

### Continuing Health Coverage for Survivors

In the event of your death, your surviving spouse may continue coverage for himself or herself and all dependent(s) covered under the UniCare State Indemnity Plan. If you have no surviving spouse, then your surviving dependent child or children may have such coverage continued until age 19.

To continue coverage, the person who has the option to continue coverage must:

1. elect to continue coverage, in writing within 30 days after the date of your death, and
2. make the required contribution toward the cost of the coverage

Coverage for survivors will end on the earliest of these dates:

1. the end of the month in which the survivor dies
2. the end of the month covered by the last contribution toward the cost of the coverage
3. the date the coverage ends
4. the date the UniCare State Indemnity Plan terminates
5. in the case of a dependent, the date that dependent would cease to qualify as a dependent, or
6. the date the survivor remarries

### Option to Continue Coverage after a Change in Marital Status

Your spouse will not cease to qualify as a dependent solely because a judgment of divorce or of separate support is granted. If that judgment is granted while the former spouse is covered as a dependent and states that coverage for the former spouse will continue, that person will continue to qualify as a dependent under the UniCare State Indemnity Plan, provided family coverage continues and neither party remarries.

**If you get divorced, you must notify the GIC and send them a copy of your divorce decree. If you or your former spouse remarry, you must also notify the GIC.**

The former spouse will no longer qualify as a dependent after the earliest of these dates:

1. the end of the period specified in the judgment during which that person must remain eligible for coverage
2. the end of the month covered by the last contribution toward the cost of the coverage
3. the date that person remarries
4. the date you remarry. If that person is still covered as a dependent on this date, and the judgment gives that person the right to continue coverage at full cost after you remarry, then that person may either elect to:
  - (a) remain covered separately for the benefits for which he or she was covered on that date
  - (b) take COBRA coverage, or
  - (c) have a converted policy issued to provide those benefits

For the purposes of this provision, “judgment” means only a judgment of absolute divorce or of separate support.

### Group Health Continuation Coverage under COBRA

This subsection contains important information about your right to continue group health coverage at COBRA group rates if your group coverage otherwise would end due to certain life events. Please read it carefully.

#### What is COBRA coverage?

COBRA, the Consolidated Omnibus Budget Reconciliation Act, is a Federal law under which certain former employees, retirees, spouses, former spouses and dependent children have the right to temporarily continue their existing group health coverage at group rates when group coverage otherwise would end due to certain life events, called “Qualifying Events.” If you elect COBRA coverage, you are entitled to the same coverage

## General Provisions

being provided under the GIC's plan to similarly situated employees or dependents. The GIC administers COBRA coverage.

This information explains your COBRA rights and what you need to do to protect your right to receive it. If you have questions about COBRA coverage contact the GIC's Public Information Unit at (617) 727-2310, ext. 1, or write to the Unit at P.O. Box 8747, Boston, MA 02114. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration's web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

### Who is eligible for COBRA coverage?

Each individual entitled to COBRA (known as a "Qualified Beneficiary") has an independent right to elect the coverage, regardless of whether or not other eligible family members elect it. Qualified Beneficiaries may elect to continue their group coverage that otherwise would end due to the following life events:

**If you are an employee covered by the GIC's health benefits program**, you have the right to choose COBRA coverage if:

- You lose your group health coverage because your hours of employment are reduced, or
- Your employment ends for reasons other than gross misconduct

**If you are the spouse of an employee covered by the GIC's health benefits program**, you have the right to choose COBRA coverage for yourself if you lose GIC health coverage for any of the following reasons (known as "qualifying events"):

- Your spouse dies
- Your spouse's employment with the Commonwealth, municipality or other entity ends for any reason other than gross misconduct or his/her hours of employment are reduced, or
- You and your spouse divorce or legally separate

**If you have dependent children who are covered by the GIC's health benefits program**, each child has the right to elect COBRA coverage if he or she loses GIC health coverage for any of the following reasons (known as "qualifying events"):

- The employee-parent dies
- The employee-parent's employment is terminated (for reasons other than gross misconduct) or the parent's hours of employment are reduced
- The parents divorce or legally separate, or
- The dependent ceases to be a dependent child

### How long does COBRA coverage last?

By law, COBRA coverage must begin on the day immediately after your group health coverage otherwise would end. If your group coverage ends due to employment termination or reduction in employment hours, COBRA coverage may last for up to 18 months. If it ends due to any other qualifying events listed above, you may maintain COBRA coverage for up to 36 months.

**If you have COBRA coverage due to employment termination or reduction in hours, your family members' COBRA coverage may be extended** beyond the initial 18-month period up to a total of 36 months (as measured from the initial qualifying event) if a second qualifying event—the insured's death or divorce—occurs during the 18 months of COBRA coverage.

**You must notify the GIC in writing within 60 days of the second qualifying event and before the 18-month COBRA period ends in order to extend the coverage.** Your COBRA coverage may be extended to a total of 29 months (as measured from the initial qualifying event) if any qualified beneficiary in your family receiving COBRA coverage is disabled during the first 60 days of your 18-month COBRA coverage. **You must provide the GIC with a copy of the Social Security Administration's disability determination within 60 days after you receive it and before your initial 18-month COBRA period ends in order to extend the coverage.**

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**COBRA coverage will end before the maximum coverage period ends if any of the following occurs:**

- The COBRA cost is not paid in full when due (see section on paying for COBRA)
- You or another qualified beneficiary become covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary's pre-existing covered condition covered by COBRA benefits
- You are no longer disabled as determined by the Social Security Administration (if your COBRA coverage was extended to 29 months due to disability)
- Your employer no longer provides group health coverage to any of its employees, or
- Any reason for which the GIC terminates a non-COBRA enrollee's coverage (such as fraud)

**The GIC will notify you in writing if your COBRA coverage is to be terminated before the maximum coverage period ends. The GIC reserves the right to terminate your COBRA coverage retroactively if you are subsequently found to have been ineligible for coverage.**

### How and when do I elect COBRA coverage?

Qualified beneficiaries must elect COBRA coverage within 60 days of the date that their group coverage otherwise would end or within 60 days of receiving a COBRA notice, whichever is later. A qualified beneficiary may change a prior rejection of COBRA election any time until that date. **If you do not elect COBRA coverage within the 60-day election period, you will lose all rights to COBRA coverage.**

There are several considerations when deciding whether to elect COBRA coverage. COBRA coverage can help you avoid incurring a coverage gap of more than 63 days, which under Federal law can cause you to lose your right to be exempt from pre-existing condition exclusions when you elect subsequent health plan coverage. If you have COBRA coverage for the maximum period available to you, it provides you the right to purchase individual health

insurance policies that do not impose such pre-existing condition exclusions. You also have special enrollment rights under Federal law, including the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your COBRA coverage ends.

### How much does COBRA coverage cost?

Under COBRA, you must pay 102 percent of the applicable cost of your COBRA coverage. If your COBRA coverage is extended to 29 months due to disability, your cost will increase to 150 percent of the applicable full cost rate for the additional 11 months of coverage. COBRA costs will change periodically.

### How and when do I pay for COBRA coverage?

If you elect COBRA coverage, you must make your first payment for COBRA coverage within 45 days after the date you elect it. **If you do not make your first payment for COBRA coverage within the 45-day period, you will lose all COBRA coverage rights under the plan.**

Your first payment must cover the cost of COBRA coverage from the time your coverage would have ended up to the time you make the first payment. **Services cannot be covered until the GIC receives and processes this first payment, and you are responsible for making sure that the amount of your first payment is enough to cover this entire period.** After you make your first payment, you will be required to pay for COBRA coverage for each subsequent month of coverage. These periodic payments are due usually around the 15th of each month. The GIC will send monthly bills, specifying the due date for payment and the address to which payment is to be sent for COBRA coverage, but **you are responsible for paying for the coverage even if you do not receive a monthly statement.** Payments should be sent to the GIC's address on the bill.

After the first payment, you will have a 30-day grace period beyond the due date on each monthly bill in which to make your monthly payment. Your COBRA coverage will be provided for each coverage period



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as long as payment for that coverage period is made before the end of the grace period for that payment. **If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA coverage.**

### Can I elect other health coverage besides COBRA?

Yes. You have the right to enroll, within 31 days after coverage ends, in an individual health insurance “conversion” policy with your current health plan without providing proof of insurability. The benefits provided under such a policy might not be identical to those provided through COBRA. You may exercise this right in lieu of electing COBRA coverage, or you may exercise this right after you have received the maximum COBRA coverage available to you.

### Your COBRA Coverage Responsibilities

- **You must inform the GIC of any address changes to preserve your COBRA rights.**
- **You must elect COBRA within 60 days from the date you receive a COBRA notice or would lose group coverage due to one of the qualifying events described above.** If you do not elect COBRA coverage within the 60-day limit, your group health benefits coverage will end and you will lose all rights to COBRA coverage.
- **You must make the first payment for COBRA coverage within 45 days after you elect COBRA.** If you do not make your first payment for the entire COBRA cost due within that 45-day period, you will lose all COBRA coverage rights.
- **You must pay the subsequent monthly cost for COBRA coverage in full by the end of the 30-day grace period after the due date on the bill.** If you do not make payment in full by the end of the 30-day grace period after the due date on the bill, your COBRA coverage will end.

- **You must inform the GIC within 60 days of the later of either (1) the date of any of the following, or (2) the date on which coverage would be lost because of any of the following events:**

- The employee’s job terminates or his/her hours are reduced
- The employee or former employee dies
- The employee divorces or legally separates
- The employee or employee’s former spouse remarries
- A covered child ceases to be a dependent
- The Social Security Administration determines that the employee or a covered family member is disabled, or
- The Social Security Administration determines that the employee or a covered family member is no longer disabled

If you do not inform the GIC of these events within the time period specified above, you will lose all rights to COBRA coverage. To notify the GIC of any of the above events within the 60 days for providing notice, send a letter to the Public Information Unit at Group Insurance Commission, P. O. Box 8747, Boston, MA 02114-8747.

### COBRA Subsidy and Special Extended Election Notice

This notice contains important information about additional rights to continue your GIC health coverage and, for some people, at a temporarily reduced premium. **Please read the information contained in this notice very carefully.**

If you have lost coverage due to an involuntary termination some time between September 1, 2008 and December 31, 2009 and you are not eligible for Medicare or other group health plan coverage, you



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may be eligible for a temporary premium reduction in COBRA rates for up to nine months. Furthermore, if you lost coverage due to an involuntary termination some time between September 1, 2008 and February 17, 2009 AND either did not elect COBRA continuation coverage at that time or you elected COBRA but discontinued the coverage, you may be eligible for a second election opportunity.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces COBRA premium in some cases. Read this notice attached to help determine if you are eligible for COBRA at a temporarily reduced premium of 35% of the usual COBRA rate for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage. If you believe you meet the criteria for the COBRA premium reduction, contact the GIC for COBRA premium reduction rates and an application, and return it to the GIC with your completed COBRA election form. You do not have to send payment with your application. If you elect COBRA and are eligible for the premium reduction, COBRA continuation coverage will begin on the date you lost your GIC-sponsored coverage, or retroactively on March 1, 2009 if you avail yourself of the Special Extended Election opportunity. The retroactive coverage is required by Federal law.

You must complete the GIC COBRA subsidy application forms and return to the GIC by no later than 60 days after you receive this notice by sending it by mail to the Public Information Unit at the GIC at P.O. Box 8747, Boston, MA 02114, or by hand delivery to the GIC, 19 Staniford Street, 4th floor, Boston, MA 02114. If you do not submit a completed election form by this deadline, you will lose your right to elect COBRA coverage. If you have any questions about this notice or your rights to COBRA continuation coverage, contact the GIC's Public Information Unit at (617) 727-2310, ext 1, or visit the GIC at 19 Staniford Street, 4th Floor, Boston, MA 02114.

### Important Information about Your COBRA Continuation Coverage Rights

#### Am I eligible for COBRA at reduced rates?

If you lost group health coverage from September 1, 2008 through December 31, 2009 due to an involuntary termination of employment that occurred during that period and are not eligible for Medicare or other group health plan coverage, you are entitled to receive the premium reduction. Information about the amount of the premium reduction and how it affects your premium payments can be found below.

#### How long will the premium reduction last?

The premium reduction will last for up to nine months as long as you:

- Are eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
- Have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
- Are not eligible for Medicare; AND
- Are not eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.

#### Am I eligible to elect COBRA continuation coverage at this time through the Special Extended Election?

Only individuals who lost group health coverage from September 1, 2008 through February 16, 2009 due to an involuntary termination of employment that occurred during that period, and who did not elect COBRA continuation coverage during their first election period OR who elected but subsequently discontinued COBRA coverage (for reasons other than becoming eligible for another group health plan or Medicare), are entitled to elect

## General Provisions

coverage at this time. If you lost group health coverage for any other reason between these dates and did not elect COBRA continuation coverage when it was first offered, you are not entitled to this second election period.

### How long will continuation coverage last?

Your coverage generally will begin on the first of the month after the month in which you were involuntarily terminated and can generally continue for up to 18 months from the date of your involuntary termination of employment. The duration of the premium reduction is determined separately and may not last for the entire length of your COBRA coverage.

Continuation coverage will be terminated before the end of the 18-month period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

### When and how must the first payment for COBRA continuation coverage be made?

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation

coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Public Information Unit, Group Insurance Commission, P.O. Box 8747, Boston, MA 02114-8747, (617) 727-2310, ext 1 to confirm the correct amount of your first payment.

### For More Information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Group Insurance Commission. If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of the health plan handbook, you may contact the Public Information Unit, Group Insurance Commission, P.O. Box 8747, Boston, MA 02114-8747 (617) 727-2310, ext 1.

### Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Group Insurance Commission.

## Conversion to Non-Group Health Coverage

Under certain circumstances, a person whose UniCare State Indemnity Plan/PLUS coverage is ending has the option to convert to non-group health coverage provided by UniCare.

A certificate for this non-group health coverage issued by UniCare can be obtained if:

1. employment for coverage purposes ends, except due to retirement, or
2. status changes occur for someone who is not eligible for continued coverage under the UniCare State Indemnity Plan/PLUS

## General Provisions

You cannot obtain a certificate of coverage if you are otherwise eligible under the UniCare State Indemnity Plan/PLUS, or if your coverage terminated for failure to make a required contribution when due. In addition, no certificate of coverage will be issued in a state or country where UniCare is not licensed to issue it.

The certificate of coverage will cover you and your dependent(s) who cease to be covered under the UniCare State Indemnity Plan/PLUS because your health coverage ends, and any child of yours born within 31 days after such coverage ends.

A certificate of coverage is also available to the following persons whose coverage under the UniCare State Indemnity Plan/PLUS ceases:

1. Your spouse and/or your dependents, if their coverage ceases because of your death
2. Your child, covering only that child, if that child ceases to be covered under the UniCare State Indemnity Plan/PLUS solely because the child no longer qualifies as your dependent
3. Your spouse and/or dependents, if their coverage ceases because of a change in marital status

The following rules apply to the issuance of the certificate of coverage:

1. Written application and the first premium must be submitted within 31 days after the coverage under the UniCare State Indemnity Plan/PLUS ends.
2. The rules of UniCare for coverage available for conversion purposes at the time application for a certificate of coverage is received govern the certificate. Such rules include: the form of the certificate; its benefits; the individuals covered; the premium payable, and all other terms and conditions of such certificate.
3. If delivery of the certificate is to be made outside of Massachusetts, it may be on such form as is offered in the state where such certificate is to be delivered.
4. The certificate of coverage will become effective on the day after coverage under the UniCare State Indemnity Plan/PLUS ends.
5. No evidence of insurability will be required.

UniCare will furnish details of converted coverage upon request.

# **PRESCRIPTION DRUG PLAN**

Description of Benefits

*Administered by*



**EXPRESS SCRIPTS®**

# Prescription Drug Plan

## Description of Benefits

Express Scripts is the pharmacy benefit manager for your prescription drug benefit plan.

The following benefit changes are effective July 1, 2009:

- Copayments for all medications, including specialty medications, have changed.
- The Value Tier has been discontinued.
- Non-sedating antihistamines (e.g., Allegra-D, Clarinex) will no longer be covered; over-the-counter (OTC) alternatives are available.

If you have any questions about your prescription drug benefits, contact the Express Scripts Customer Service Call Center toll free at (877) 828-9744, TDD: (800) 855-2881.

## About Your Plan

Prescription medications are covered by the plan only if they have been approved by the U.S. Food and Drug Administration (FDA). In addition, with the exception of the over-the-counter version of Prilosec (Prilosec OTC), medications are covered only if a prescription is required for their dispensing. Diabetic supplies and insulin are also covered by the plan.

The plan categorizes medications into six major categories:

### Generic Drugs

Generic versions of brand medications contain the same active ingredients as their branded counterparts, thus offering the same clinical value. The FDA requires generic drugs to be just as strong, pure and stable as brand name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand name drugs.

### Maintenance Drug

A maintenance drug is a medication taken on a regular basis for conditions such as asthma, heartburn, high-blood pressure or high-cholesterol.

### Non-Preferred Brand Name Drug

A non-preferred brand name drug, or non-formulary drug, is a medication that usually has an alternative therapeutically-equivalent drug available.

### Preferred Brand Name Drug

A preferred brand name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, the Express Scripts Pharmacy and Therapeutics Committee, and has been selected by Express Scripts for formulary inclusion based on its proven clinical and cost-effectiveness.

### Specialty Drugs

Specialty drugs are injectable and noninjectable drugs that have one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and to increase the probability for beneficial treatment outcomes
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals
- Limited or exclusive product availability and distribution
- Specialized product handling and/or administration requirements
- Cost in excess of \$500 for a 30-day supply

### Over-the-Counter (OTC) Drugs

Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of Prilosec OTC (which is covered if dispensed with a written prescription).

## Prescription Drug Plan

### Copayments

One of the ways your plan maintains coverage of quality, cost-effective medications is a multi-tier copayment pharmacy benefit. The following chart shows your copayment based on the type of prescription you fill and where you get it filled.

| Copayment for  | Participating Retail Pharmacy up to 30-day supply        | Home Delivery up to 90-day supply |
|--|--|-----------------------------------|
| <b>Tier 1</b><br><b>Generic Drugs and</b><br>▪ Prilosec OTC (28-day supply – retail; 84-day supply – mail)*    | \$10   | \$20                              |
| <b>Tier 2</b><br><b>Preferred Brand Name Drugs</b>   | \$25   | \$50                              |
| <b>Tier 3</b><br><b>Non-Preferred Brand Drugs and</b><br>▪ COX-2 inhibitors (pain and inflammation – Celebrex) | \$50   | \$110                             |
| Copayment for  | Specialty Drugs – Must Be Filled Only Through CuraScript |                                   |
| <b>Specialty Drugs: Tier 1</b>   | \$10 up to a 30-day supply                               |                                   |
| <b>Specialty Drugs: Tier 2</b>   | \$25 up to a 30-day supply                               |                                   |
| <b>Specialty Drugs: Tier 3</b>   | \$50 up to a 30-day supply                               |                                   |

\*Due to manufacturer packaging



## How to Use the Plan

### Filling Your Prescriptions

You may fill your prescriptions at a participating retail pharmacy or through Express Scripts Home Delivery (Mail Order). Prescriptions for specialty drugs must be filled through CuraScript.

To obtain benefits at a retail pharmacy, you must fill your prescription at a participating pharmacy using your Express Scripts ID card, with the exception of the limited circumstances detailed in the “Claim Forms” subsection.

### Short-Term Medication Needs – Up to 30 Days

#### Filling Your Prescriptions at a Participating Retail Pharmacy

The retail pharmacy is your most convenient option when you are filling a prescription for a short-term prescription that you need immediately (example: antibiotics for strep throat or painkillers for an injury). Simply present your Express Scripts ID card to your pharmacist, along with your written prescription, and pay the required copayment. Prescriptions filled at a non-participating retail pharmacy are not covered.

You can locate the nearest participating retail pharmacy anytime online at [www.express-scripts.com](http://www.express-scripts.com) or by calling toll free at (877) 828-9744.

If you do not have your ID card, you can provide your pharmacist with the cardholder’s Social Security or GIC ID number, and the group number, which is GICA. The pharmacist will also be able to verify eligibility by contacting the Express Scripts Pharmacy Help Desk toll free at (800) 824-0898, TDD: (800) 842-5754.

If you are filling maintenance medications at a retail pharmacy, you may receive phone calls and/or letters from Express Scripts explaining how to convert your maintenance medications to mail order. You will need to let Express Scripts know if you would like to use mail order or instead to continue using a retail pharmacy. Express Scripts

will either assist you in transitioning your maintenance medications to mail order, or if you choose not to use mail, they will continue to make sure you receive your maintenance medications at retail.

### Long-Term Medication Needs

#### Filling Your Prescriptions Through the Express Scripts Pharmacy

Home Delivery (Mail Order) is your best option for prescription drugs (other than specialty drugs filled through CuraScript) that you take on a regular basis for conditions such as asthma, heartburn, high-blood pressure, and high-cholesterol. Your prescriptions are filled and double-checked by Express Scripts’ licensed pharmacists and conveniently sent to you in a plain, weather-resistant pouch for privacy and protection.

#### Convenient for You

You get up to a 90-day supply of your medications—which means fewer refills and fewer visits to your pharmacy, as well as lower copayments. Once you begin using Home Delivery, you can order refills online, by phone or by mail.

#### Using Home Delivery

To begin using Home Delivery for your prescriptions, just follow these three simple steps:

1. Ask your physician to write a prescription for up to a 90-day supply of your medication plus refills for up to one year, if appropriate. (Remember also to ask for a second prescription for an initial 30-day supply and take it to your local participating retail pharmacy.)
2. Complete a Home Delivery order form. (You can obtain a Home Delivery order form and envelope anytime online at [www.express-scripts.com](http://www.express-scripts.com) or by calling toll free at (877) 828-9744.)
3. Put your prescription, payment and completed order form into the mail order envelope and mail it to Express Scripts.

## Prescription Drug Plan

Your prescription drug will be mailed to your home in 10 to 14 business days from the day you mailed the prescription to Express Scripts, with no charge for standard U.S. Postal Service delivery. You can request overnight delivery for an additional charge.

A pharmacist is available 24 hours a day to answer your questions about your medication.

If the Express Scripts pharmacy is unable to fill a prescription because of a shortage of the medication, Express Scripts will notify you of the delay in filling the prescription. You may then attempt to fill the prescription at a retail pharmacy, but the retail pharmacy copayment will then apply.

### Express Scripts' Specialty Pharmacy

CuraScript is a full-service specialty pharmacy that provides personalized care to each patient. All specialty drugs must be filled through CuraScript pharmacy. You are allowed two fills of your specialty drug(s) at a participating retail pharmacy. After these two fills, your specialty drug(s) will no longer be covered through other pharmacies.

CuraScript offers a complete range of services and specialty drugs—many of which are often unavailable at retail pharmacies. Your specialty drugs are quickly delivered to any approved location, at no additional charge. You can save time with convenient toll-free access to expert clinical support staff who are available to answer all of your specialty drug questions. CuraScript will provide you with ongoing refill reminders before you run out of your medications.

To begin receiving your specialty drugs through CuraScript, call CuraScript toll free at (866) 848-9870.

### CuraScript Services

- **Patient Counseling** – Convenient access to pharmacists and nurses who are specialty medication experts
- **Patient Education** – Educational materials
- **Convenient Delivery** – Coordinated delivery to your home, your doctor's office or other approved location

- **Refill Reminders** – Ongoing refill reminders from CuraScript
- **Language Assistance** – Language interpreting services are provided for non-English speaking patients

CuraScript serves a wide range of patient populations, including those with hemophilia, hepatitis, HIV/AIDS, cancer, multiple sclerosis, rheumatoid arthritis, post-transplant needs and more.

### Claim Forms

Retail purchases out of the country, or purchases at a participating retail pharmacy without the use of your Express Scripts ID card, are covered as follows:

| Type of Claim   | Reimbursement   |
|---|---|
| Claims for prescriptions for enrollees who reside in a nursing home or live or travel outside the U.S. or Puerto Rico.* | Claims will be reimbursed at the full cost submitted less the applicable copayment.   |
| Claims for purchases at a participating (in-network) pharmacy without an Express Scripts ID card.                       | Claims incurred within 30 days of the enrollee's eligibility effective date will be covered at full cost, less the applicable copayment.<br><br>-or-<br><br>Claims incurred more than 30 days after the enrollee's eligibility effective date will be reimbursed at a discounted cost, less the applicable copayment. |

\* Claims for medications filled outside the United States and Puerto Rico are covered only if the medications have U.S. equivalents.

# Prescription Drug Plan

## Visit [express-scripts.com](http://express-scripts.com)

### Get the Information You Need When You Need It

Express-scripts.com provides 24-hour online access to information regarding your prescription benefit. Visit the website to:

- Find out about your copayment amounts
- Verify coverage for eligible dependents
- View or print a list of drugs included in your formulary
- Locate participating retail pharmacies near you
- Review your 12-month prescription history
- Order refills online
- Check the status of your mail order prescription

### Register Now to Access [express-scripts.com](http://express-scripts.com)

Accessing your prescription benefit online is quick, easy and secure; just go to [www.express-scripts.com](http://www.express-scripts.com) and complete a brief registration process to get started. You'll have the information you need about your prescription benefits, right at your fingertips.

## Other Plan Provisions

### Generics Preferred

Generics Preferred is a program that encourages the use of generic drugs. There are some brand name drugs, such as Ambien and Fosamax, for which generic equivalents are available. If you fill a prescription for a brand-name medication for which there is a generic equivalent, the standard brand copayment will not apply. Instead, you will be responsible for the full difference in price between the brand-name drug and the generic drug, plus the generic copayment.

### Prescription Drugs with OTC Equivalents or Alternatives

Some prescription drugs have OTC equivalent products available. These OTC products have strengths, active chemical ingredients, routes of administration and dosage forms identical to the prescription drug products. Your plan does not provide benefits for these prescription drugs.

Some prescription drugs also have OTC product alternatives available. These OTC products, though not identical, are very similar to the prescription drugs. For example, OTC alternatives to Clarinex, a prescription drug, are the OTC products Claritin and Zyrtec. Your plan does not provide benefits for prescription drugs when OTC alternatives are available.

### Prior Authorization

Some drugs on your plan require prior authorization. If a drug that you take requires prior authorization, your physician will need to contact Express Scripts to see if the prescription meets the plan's conditions for coverage. If you are prescribed a drug that requires prior authorization, your physician should call (800) 417-8164.

#### Drugs that currently require Prior Authorization\*

|           |            |             |
|-----------|------------|-------------|
| Actiq     | Humira     | Regranex    |
| Amevive   | Hyalgan    | Remicade    |
| Aralast   | Immune     | Revatio     |
| Aranesp   | Globulin   | Somavert    |
| Amevive   | products   | Sporanox    |
| Avonex    | Kineret    | Supartz     |
| Betaseron | Lamisil    | Synvisc     |
| Botox     | Myobloc    | Tazorac     |
| Byetta    | Neulasta   | Topamax     |
| Cerezyme  | Neupogen   | Tysabri     |
| Copaxone  | Orencia    | Vfend       |
| Enbrel    | Orthovisc  | Weight Loss |
| Epogen    | Pegasys    | Drugs such  |
| Euflexxa  | Peg-Intron | as Xenical  |
| Fabrazyme | Penlac     | and Merida  |
| Fentora   | Privigen   | Xolair      |
| Forteo    | Procrit    | Zemaira     |
| Growth    | Prolastin  | Zonegran    |
| Promoting | Raptiva    |             |
| Agents    | Rebif      |             |

*For members over the age of 35: Retin-A, Retin-A Micro, Avita, Tretin-X, Atralin gel, topical tretinoin, Ziana*

\* This list may change during the plan year.

# Prescription Drug Plan

## Quantity Per Dispensing Limits

To promote member safety and appropriate and cost-effective use of medications, your prescription plan includes a drug quantity management program. This means that for certain prescription drugs, there are limits on the quantity of the drug that you may receive at one time.

Quantity per dispensing limits are based on the following:

- The manufacturer's recommended dosage and duration of therapy
- Common usage for episodic or intermittent treatment
- FDA-approved recommendations and/or clinical studies
- As otherwise determined by your plan

Examples of drugs with quantity limits currently include Actonel, Avandia, Flonase, Imitrex, Lunesta, Levitra, and Viagra.\*

## Step Therapy

In some cases, your plan requires the use of less expensive first-line prescription drugs before the plan will pay for more expensive second-line prescription drugs. First-line prescription drugs are safe and effective medications used for the treatment of medical conditions or diseases. Your prior claims history, if you are a continuing member of the plan, will show whether first-line prescription drugs have been purchased within the previous 160 days, allowing the more-expensive medication to be approved without delay.

If you have not had a medication filled within the previous 160 days while a member of this plan, it is not considered a current prescription and the Step Therapy requirements will apply to your prescription.

In certain situations, a member may be granted an authorization for a second-line prescription drug without the prior use of a first-line prescription drug if specific medical criteria have been met.

Unless you meet certain medical criteria or have a prior history of use of the first-line prescription drug, your pharmacist will receive a message that the prescription will not be covered. The message will list alternative, first-line drugs that could be used. You or your pharmacist will then need to contact your physician to have your prescription changed, or you will have to pay the full cost of the prescription. If you are using Home Delivery, Express Scripts will notify you of a delay in filling your prescription and will contact your physician about switching to a first-line prescription drug. If your physician does not respond within two business days, Express Scripts will not fill your prescription and will return it to you.

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\* This list may change during the plan year.

## Prescription Drug Plan

| Current examples of second-line prescription drugs requiring Step Therapy* |  |
|--|--|
| ADD/ADHD   | Strattera  |
| Allergies  | Accolate, Nasacort AQ, Rhinocort Aqua, Singulair, and Zyflo  |
| Antidepressants  | Celexa, Cymbalta, Effexor XR, Lexapro, Paxil CR and Zoloft   |
| Antipsychotic  | Symbyax  |
| Diabetes   | Actos, Avandia, Avandamet, Avandaryl, Duetact  |
| High-Blood Pressure  | Accupril, Aceon, Altace, Atacand/HCT, Avapro, Avalide, Cardene, Coreg, Cozaar/HCT, Diovan/HCT, Lexxel, Lotrel, Mavik, Micardis/HCT, Monopril/HCT, Norvasc, Sular, Tarka, Teveten, Toprol XL and Uniretic |
| High-Cholesterol   | Caduet, Lescol, Lipitor and Zetia  |
| Incontinence   | Detrol LA, Enablex, Oxytrol, Sanctura, VESIcare  |
| Insomnia   | Ambien CR, Lunesta, Rozerem and Sonata   |
| Neuropathy   | Lyrica   |
| Pain/Arthritis   | Arthrotec, Celebrex, Ponstel and Mobic   |
| Stomach Ulcers   | Aciphex, Nexium, Prevacid and Protonix   |
| Topical Dermatitis   | Elidel and Protopic  |

### Drug Utilization Review Program

Each prescription drug purchased through this plan is subject to utilization review. This process evaluates the prescribed drug to determine if any of the following conditions exist:

- Adverse drug-to-drug interaction with another drug purchased through the plan;
- Duplicate prescriptions;
- Inappropriate dosage and quantity; or
- Too early refill of a prescription.

If any of the above conditions exist, medical necessity must be determined before the prescription drug can be processed.

### Exclusions

Benefits exclude:\*

- Smoking cessation programs or medications
- Dental preparations
- Over-the-counter drugs, vitamins or minerals (with the exception of diabetic supplies and Prilosec OTC)
- Vitamins or minerals prescribed in the absence of certain medical conditions (with the exception of prenatal vitamins)
- Homeopathic drugs
- Prescription products for cosmetic purposes such as photo-aged skin products and skin depigmentation products
- Medications in unit dose packaging
- Impotence medications for members under the age of 18
- Allergens
- Hair growth agents
- Special medical formulas or food products, except as required by state law

\* This list may change during the plan year.



# Prescription Drug Plan

## Definitions

**Brand Name Drug** – The brand name is the trade name under which the product is advertised and sold, and is protected by patents so that it can only be produced by one manufacturer for 17 years. Once a patent expires, other companies may manufacture a generic equivalent, providing they follow stringent FDA regulations for safety.

**Copayment** – A copayment is the amount that members pay for covered prescriptions. If the plan's contracted cost for a medication is less than the applicable copayment, the member pays only the lesser amount.

**Diabetic Supplies** – Diabetic supplies include needles, syringes, test strips, lancets and blood glucose monitors.

**Formulary** – A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The Express Scripts formulary contains a wide range of generic and preferred brand name products that have been approved by the Food and Drug Administration (FDA). The formulary applies to medications that are dispensed in either the retail pharmacy or home delivery settings. The formulary is developed and maintained by Express Scripts. Formulary designations may change as new clinical information becomes available.

**Generic Drugs** – Generic versions of brand medications contain the same active ingredients as their branded counterparts, thus offering the same clinical value. The U.S. Food and Drug Administration (FDA) requires generic drugs to be just as strong, pure and stable as brand name drugs. They must also be of the same quality and manufactured to the same rigorous standards. These requirements assure that generic drugs are as safe and effective as brand name drugs.

**Maintenance Drug** – A maintenance drug is a medication taken on a regular basis for conditions such as asthma, heartburn, high-blood pressure or high-cholesterol.

**Non-Preferred Brand Name Drug** – A non-preferred brand name drug, or non-formulary drug, is a medication that has been reviewed by the Express Scripts Pharmacy and Therapeutics Committee, which determined that an alternative drug that is clinically equivalent and more cost-effective may be available.

**Over-the-Counter (OTC) Drugs** – Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of Prilosec OTC (which is covered if dispensed with a written prescription).

**Participating Pharmacy** – A participating pharmacy is a pharmacy in the Express Scripts nationwide network. All major pharmacy chains and most independently-owned pharmacies participate.

**Preferred Brand Name Drug** – A preferred brand name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, the Express Scripts Pharmacy and Therapeutics Committee, and has been selected by Express Scripts for formulary inclusion based on its proven clinical and cost-effectiveness.

**Prescription Drug** – A prescription drug is any medical substance, the label of which under the Federal Food, Drug, and Cosmetic Act, must bear the legend: "Caution Federal Law prohibits dispensing without a prescription." The term prescription drug also includes insulin and diabetic supplies.

**Prior Authorization** – Prior authorization means determination of medical necessity. It is required before prescriptions for certain drugs will be paid by the plan.



## Prescription Drug Plan

### **Special Medical Formulas or Food Products –**

Special medical formulas or food products means nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids.

For inherited diseases of amino acids and organic acids, food products modified to be low protein are covered up to \$5,000 per calendar year per member. To access the benefit for special medical formulas or food products, members must first call the Group Insurance Commission at (617) 727-2310, extension 1.

**Specialty Drugs** – Specialty drugs are injectable and noninjectable drugs that have one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and to increase the probability for beneficial treatment outcomes
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals
- Limited or exclusive product availability and distribution
- Specialized product handling and/or administration requirements
- Cost in excess of \$500 for a 30-day supply

## Other Plan Information

### **Claims Inquiry**

If you believe your claim was incorrectly denied or you have questions about a prescription, call Express Scripts Customer Service Call Center toll free at (877) 828-9744, TDD: (800) 855-2881.

### **Health and Prescription Information**

Health and prescription information about members is used by Express Scripts to administer your benefits. As part of the administration, Express Scripts may report health and prescription information to the administrator or sponsor of your benefit plan. Express Scripts also uses that information and prescription data gathered from claims nationwide for reporting and analysis without identifying individual members.

# UNITED BEHAVIORAL HEALTH

Description of Benefits



**OptumHealth**<sup>SM</sup>  
Behavioral Solutions

### Part I – How to Use This Plan

#### A Comprehensive Plan Designed with Your Well-Being in Mind

As a covered person under UniCare State Indemnity Plan/PLUS, you are automatically enrolled in the mental health and substance abuse benefits program as well as the Enrollee Assistance Program (EAP) administered by United Behavioral Health. These programs offer you easy access to a broad range of services – from assistance with day-to-day concerns (e.g., legal and financial consultations, workplace-related stress, child- and elder-care referrals) to more serious mental health and substance abuse needs, including assistance in a psychiatric emergency. By offering effective, goal-focused care delivered by a network of highly qualified providers, this program is designed to improve well-being and functioning as quickly as possible.

United Behavioral Health (UBH) administers the benefits under this program on behalf of the Group Insurance Commission (GIC). With a proven track record of providing EAP services and managing care for more than 43 million people, UBH can successfully meet the diverse needs of UniCare State Indemnity Plan/PLUS covered persons.

#### United Behavioral Health Will Be Branded as OptumHealth Behavioral Solutions

Effective January 1, 2009, UBH will be operating under the brand name of OptumHealth Behavioral Solutions. This new brand name illustrates their continuing mission to optimize the health and well-being of GIC members.

Please note that this is only a brand name, and it will not affect any of their operations and procedures as described in this handbook. Their corporate entity is still registered as United Behavioral Health.

#### Let Us Show You the Benefits

The following describes your mental health, substance abuse and EAP benefits under the UBH/OptumHealth Behavioral Solutions plan. Please read it carefully before you seek care to ensure that you receive maximum benefits. The chart on pages 88–89 provides a brief overview of your benefits; however, it is not a detailed description. The detailed description of your benefits is found in Part III on pages 90–94. Words in italics throughout this description are defined in the “Definitions” section in Part II.

#### How to Ensure Maximum Benefits

In order to receive maximum benefits and reduce your out-of-pocket expenses, there are two important steps you need to remember:

**Step 1: Call UBH/OptumHealth Behavioral Solutions for *precertification* before you seek EAP, mental health, or substance abuse services; and**

**Step 2: Use a provider or facility from the UBH/OptumHealth Behavioral Solutions network.**

UBH/OptumHealth Behavioral Solutions offers you a comprehensive network of resources and experienced providers from which to obtain EAP, mental health and substance abuse services. All UBH/OptumHealth Behavioral Solutions *network providers* have been reviewed by UBH/OptumHealth Behavioral Solutions for their ability to provide quality care. If you receive care from a provider or facility that is not part of the UBH/OptumHealth Behavioral Solutions network, your benefit level will be lower than the network level. These reduced benefits are defined as *out-of-network benefits*. If you fail to call UBH/OptumHealth Behavioral Solutions to *precertify* your care, you may be charged a penalty and your benefits may be reduced. In some cases if you fail to *precertify* your care, no benefits will be paid. Please refer to Part III, titled **Benefits Explained**, on pages 90–94, for a full description of your *network* and *out-of-network benefits*, as well as special *precertification* requirements for *out-of-network* outpatient services. **Benefits will be denied if your care is considered not to be a covered service.**

Words in italics are defined in Part II.

### Before You Use Your Benefits

#### Precertification

*Precertification* is the first step to obtaining your EAP, mental health and substance abuse benefits. To receive EAP services or before you begin mental health and substance abuse care, call UBH/OptumHealth Behavioral Solutions at (888) 610-9039 (TDD: (800) 842-9489).

A trained UBH/OptumHealth Behavioral Solutions clinician will answer your call 24 hours a day, seven days a week, verify your coverage and refer you to a specialized EAP resource or a *network provider*. All UBH/OptumHealth Behavioral Solutions clinicians are experienced professionals with master's degrees in psychology, social work, or a related field. A UBH/OptumHealth Behavioral Solutions clinician will immediately be available to assist you with routine matters or in an emergency. If you have specific questions about your benefits or claims, call a customer service representative from 9 a.m. to 8 p.m. Eastern Time at (888) 610-9039 (TDD: (800) 842-9489).\*

Based on your specific needs, the UBH/OptumHealth Behavioral Solutions clinician will *precertify* visits if you are eligible for coverage at the time of your call, and provide you with the names of several mental health, substance abuse or EAP providers who match your request (e.g., provider location, gender, or fluency in a second language). UBH/OptumHealth Behavioral Solutions maintains an extensive database of information on every provider in the network. (A directory of UBH/OptumHealth Behavioral Solutions providers can be found on the UBH/OptumHealth Behavioral Solutions web site, [www.liveandworkwell.com](http://www.liveandworkwell.com) (access code 10910)). After *precertification*, you can then call the provider directly to schedule an appointment.

If you need assistance, a UBH/OptumHealth Behavioral Solutions clinician can help you in **scheduling an appointment**. The UBH/OptumHealth Behavioral Solutions clinician can also provide you with a referral for legal, financial, or dependent care assistance or community resources, depending on your specific needs.

#### Emergency Care

Emergency care is required when a person needs immediate clinical attention because he or she presents a real and significant risk to him/herself or others. In a life-threatening emergency, you and/or your covered dependents should seek care immediately at the closest emergency facility. You, a family member or your provider must call UBH/OptumHealth Behavioral Solutions **within 24 hours** of an emergency admission to notify UBH/OptumHealth Behavioral Solutions of the admission. Although a representative may call on your behalf, it is always the covered person's responsibility to ensure that UBH/OptumHealth Behavioral Solutions has been notified. If UBH/OptumHealth Behavioral Solutions is not notified of the admission, you will not be eligible for maximum benefits or benefits may be denied. UBH/OptumHealth Behavioral Solutions staff is available 24 hours a day to assist you and/or your covered family members.

#### Urgent Care

There may be times when a condition shows potential for becoming an emergency if not treated immediately. In such urgent situations, our providers will have an appointment to see you within 24 hours of your initial call to UBH/OptumHealth Behavioral Solutions.

\* As part of UBH's/OptumHealth Behavioral Solutions' quality control program, supervisors monitor random calls to UBH's/OptumHealth Behavioral Solutions' customer services department, but not the clinical department.

Words in italics are defined in Part II.

## Mental Health, Substance Abuse & EAP Services

### Routine Care

Routine care is for conditions that present no serious risk, and are not in danger of becoming an emergency. For routine care, *network providers* will have appointments to see you within three days of your initial call to UBH/OptumHealth Behavioral Solutions.

### Enrollee Assistance Program

Your Enrollee Assistance Program benefit provides access to a range of resources, as well as focused, confidential, short-term counseling to treat problems of daily living (e.g., emotional, marital or family problems, legal disputes, or financial difficulties). The EAP benefit provides counseling and other professional services to you and your family members who are experiencing problems disrupting your personal and professional lives (e.g., international events, community trauma). The EAP can also provide critical incident response and on-site behavioral health consultation for state agencies and municipalities.

### Confidentiality

When you use your EAP, mental health and substance abuse benefits under this plan, you are consenting to the release of necessary clinical records to UBH/OptumHealth Behavioral Solutions for *case management* and benefit administration purposes. Information from your clinical records will be provided to UBH/OptumHealth Behavioral Solutions only to the minimum extent necessary to administer and manage the care provided when you use your EAP, mental health and substance abuse benefits, and in accordance with state and federal laws. All of your records, correspondence, claims, and conversations with UBH/OptumHealth Behavioral Solutions staff are kept **completely confidential** in accordance with federal and state laws. No information may be released to your supervisor, employer, or your family without your written permission, and no one will be notified

when you use your EAP, mental health and substance abuse benefits. UBH/OptumHealth Behavioral Solutions staff must comply with a strict confidentiality policy.

### Complaints

If you are not satisfied with any aspect of the UBH/OptumHealth Behavioral Solutions program, we encourage you to call UBH/OptumHealth Behavioral Solutions at (888) 610-9039 (TDD: (800) 842-9489) to speak with a customer service representative. The UBH/OptumHealth Behavioral Solutions member services representative resolves most inquiries during your initial call. Inquiries that require further research are reviewed by representatives of the appropriate departments at UBH/OptumHealth Behavioral Solutions, including clinicians, claims representatives, administrators, and other management staff who report directly to senior corporate officers. We will respond to all inquiries within three business days. Your comments will help us correct any problems and provide better service to you and your dependents. If the resolution of your inquiry is unsatisfactory to you, you have the right to file a formal *complaint* in writing within 60 days of the date of our telephone call or letter of response. Please specify dates of service and additional contact with UBH/OptumHealth Behavioral Solutions and include any information you feel is relevant. Formal *complaints* will be responded to in writing within 30 days. A formal *complaint* should be sent to:

United Behavioral Health  
Complaint Unit  
100 East Penn Square  
Suite 400  
Philadelphia, PA 19107

### Your Rights to an Appeal Review

You, an authorized representative, or your treating provider acting on your behalf has the right to appeal the benefit decision made by United Behavioral Health (UBH). You may request an appeal either verbally or in writing by following the steps below.

You have the right to file an urgent or non-urgent appeal. An urgent appeal can be requested if a delay in treatment places your health or the health of others in serious jeopardy, significantly increases the risk to your health, results in severe pain, or affects your ability to regain maximum functioning.

If you have questions after reviewing the following information, please call (800) 548-6539 x39291.

### How to Initiate an Internal Appeal Review through UBH

You may initiate your appeal in writing or verbally by contacting UBH at the address or toll-free telephone number listed below:

United Behavioral Health  
Appeals Department  
100 East Penn Square  
Suite 400  
Philadelphia, PA 19107  
Phone: (800) 548-6549 x39291  
Fax: (888) 881-7453

Your appeal request must include the following:

- Your name and identification number from your ID card.
- The date(s) of service(s).
- Type of treatment.
- Your treating provider's name.
- Any additional information you would like to have considered as part of the appeal process. Examples of such information are: records relating to the current conditions of treatment, co-existent conditions, or any other relevant information.

For clinical cases, a board-certified physician in the same or similar specialty area as your treating physician will review and make the decision about your appeal request. If your treating provider is not a physician, a doctoral-level psychologist or a physician will review and make a decision about your appeal request. The UBH physician or psychologist will not have had any previous involvement in decisions about your case.

### The First Level Internal Appeal Review Process

**Non-Urgent Process** – You must request an appeal within one hundred eighty (180) calendar days of the date you received your adverse determination letter from UBH. UBH will notify you or your authorized representative and your health care provider of the appeal resolution in writing within thirty (30) calendar days of the receipt of your request. If this is an appeal of services you have not yet received, UBH will complete the review and notify you of the outcome within fifteen (15) calendar days of the receipt of your request.

**Urgent Process** – If a delay in treatment places your health or the health of others in serious jeopardy, significantly increases the risk to your health, results in severe pain, or affects your ability to regain maximum function, you can request an urgent appeal. You or your provider should call UBH as soon as possible using the phone number listed above. An urgent appeal will be reviewed, a decision made, and you and your provider will be notified within seventy-two (72) hours of the receipt of your request.



### The Second Level External Appeal Review Process

If you have completed your urgent or non-urgent first level appeal options and remain dissatisfied with the outcome, you may request a voluntary external review. You must contact UBH within one hundred eighty (180) calendar days of the date you received the final determination from UBH. To qualify for a voluntary external review, you must meet the following criteria:

- The adverse benefit determination must have been clinical in nature.
- The appeal is for coverage of a benefit that is expressly included in your benefit plan.
- You have not agreed to any other dispute resolution proceedings with UBH.
- The dollar amount of the services you are appealing must be at least \$500.00.

An independent external review will be completed within thirty (30) calendar days of the receipt of your request by a review agency independent of UBH. If your treating provider or UBH identifies the appeal as clinically urgent, the review will be completed within three (3) calendar days of the receipt of your request, with the possibility of extending to five (5) calendar days for good cause. You are not required to bear the cost of the independent external review, including any filing fees.

### How to Initiate a Third Level Review with the Commonwealth of Massachusetts Group Insurance Commission (GIC)

If you have completed your first level internal and second level external appeal options and remain dissatisfied with the outcome, you may seek review with the Group Insurance Commission. The request must be made in writing to the Group Insurance Commission within thirty (30) days of the receipt of the Second Level Appeal outcome letter.

To request a review by the Group Insurance Commission, contact the Group Insurance Commission at the address listed below:

Executive Director  
Group Insurance Commission  
Commonwealth of Massachusetts  
P.O. Box 8747  
Boston, MA 02114-8747

You may also fax your review request to the GIC by first phoning the Legal Department at (617) 727-2310, x7014 and then faxing your documents to (617) 227-5181.

Prior to the appeal review being conducted, you and your provider have the opportunity to submit any additional information or documentation that you would like to have considered as part of the review.

The Group Insurance Commission will notify you, your authorized representative and your health care provider of the review resolution in writing within thirty (30) calendar days of receipt of your review request.

You are not required to bear the cost of the independent external review, including any filing fees.

UBH must comply with the Group Insurance Commission's decision.

### Additional Rights

You may request paper copies, free of charge, of any relevant documents, records, or other information UBH used to make its appeal decision. To request a paper copy of your record, contact UBH at the address or telephone number listed above.

### Filing Claims

*Network providers* and facilities will file your claim for you. You are financially responsible for *deductibles* and *copayments*.

*Out-of-network providers* are not required to process claims on your behalf; you must submit the claims yourself. You are responsible for all *coinsurance*, and *deductibles*. Send the *out-of-network provider's* itemized bill and a completed CMS 1500 claim form, with your name, address, and GIC ID number to:

United Behavioral Health  
Claims  
Post Office Box 30755  
Salt Lake City, UT 84130-0755

The CMS 1500 form is available from your provider. Claims must be received by UBH/OptumHealth Behavioral Solutions within 15 months of the date of service for you or a covered dependent. You must be eligible for coverage on the date you received care. All claims are confidential.

### Coordination of Benefits

All benefits under this plan are subject to *coordination of benefits*, which determines whether your mental health and substance abuse care is partially or fully covered by another plan. UBH/OptumHealth Behavioral Solutions may request information from you about other health insurance coverage in order to process your claim correctly.

### For More Information

UBH/OptumHealth Behavioral Solutions customer service staff is available to help you. Call (888) 610-9039 (TDD: (800) 842-9489) for assistance Monday through Friday, from 9 a.m. to 8 p.m. Eastern Time.

## Part II – Benefit Highlights

### Definitions of UBH/OptumHealth Behavioral Solutions Terms

**Allowed Charges** means charges conform to UBH/OptumHealth Behavioral Solutions negotiated fee maximums or reasonable and customary rates. If the cost of treatment for out-of-network care exceeds the *allowed charges*, the covered person may be responsible for the difference.

**Appeal** means a formal request for UBH/OptumHealth Behavioral Solutions to reconsider any adverse determination/denial of coverage, either concurrently or retrospectively, for admissions, continued stays, levels of care, procedures, or services.

**Case Management** means a system of *continuing review* by a UBH/OptumHealth Behavioral Solutions clinical case manager, using objective clinical criteria, to determine if treatment is appropriate and a covered service according to the plan of benefits for a covered diagnostic condition.

**Coinsurance** means the limit of coverage by the plan to a certain percentage of provider costs and fees, such as 80%. The remaining percentage is paid by the covered person. The provider is responsible for billing the member for the remaining percentage.

**Complaint** means a verbal or written statement of dissatisfaction arising from a perceived adverse administrative action, decision, or policy by UBH/OptumHealth Behavioral Solutions.

**Continuing Review/Concurrent Review** means an assessment of the care while it is being delivered and the proposed treatment plan for future care, conducted at periodic intervals by a clinical case manager to determine the appropriateness of continued care.

## Mental Health, Substance Abuse & EAP Services

**Coordination of Benefits (COB)** means a methodology that determines the order and proportion of insurance payment when a covered person has coverage through more than one insurer. The regulations define which organization has primary responsibility for payment and which organization has secondary responsibility for any remaining charges not covered by the “primary plan.”

**Copayment** means a fixed dollar amount that a covered person must pay out of his or her own pocket.

**Covered Services** are services and supplies provided for the purpose of preventing, diagnosing or treating a behavioral disorder, psychological injury or substance abuse addiction and which are described in the section titled “What This Plan Pays,” and not excluded under the section titled “What’s Not Covered – Exclusions.”

**Cross Accumulation** means the sum of applicable expenses paid by a covered person to determine whether a *deductible* or *out-of-pocket maximum* has been reached.

**Deductible** means the designated amount that a covered person must pay for any charges before insurance coverage applies.

**Intermediate Care** means care that is more intensive than traditional outpatient treatment but less intensive than 24-hour hospitalization. Some examples are residential treatment, group homes, halfway houses, therapeutic foster care, day or partial hospital programs, or structured outpatient programs.

**Network Provider** is a provider who participates in the UBH/OptumHealth Behavioral Solutions network.

**Non-Notification Penalty** means the amount charged when you fail to *precertify* care. It does not count towards the *out-of-pocket maximum*.

**Out-of-Network Provider** is a provider who does not participate in the UBH/OptumHealth Behavioral Solutions network.

**Out-of-Pocket Maximum** means the maximum amount you will pay in *coinsurance* and *copayments* for your mental health and substance abuse care in one calendar year. When you have met your *out-of-pocket maximum*, all care will be covered at 100% of the *allowed charge* until the end of that calendar year. This maximum does not include the *non-notification penalty*, charges for out-of-network care that exceed the maximum number of covered days or visits, out-of-network outpatient service costs, the out-of-network calendar year *deductible*, the out-of-network inpatient *deductible*, charges for care not deemed to be a covered service, and charges in excess of UBH’s/OptumHealth Behavioral Solutions’ *allowed charges*.

**Precertification (Precertify)** is the process of registering for services with UBH/OptumHealth Behavioral Solutions prior to seeking EAP, mental health and substance abuse care. All *precertification* is performed by *UBH/OptumHealth Behavioral Solutions clinicians*.

**UBH/OptumHealth Behavioral Solutions Clinician** refers to the staff member who *precertifies* EAP, mental health and substance abuse services. *UBH/OptumHealth Behavioral Solutions clinicians* must have the following qualifications: Master’s degree in psychology, social work, or a related field; three or more years of clinical experience; Certified Employee Assistance Professionals (CEAP) certification or eligibility; and a comprehensive understanding of the full range of EAP services for employees and employers, including workplace and personal concerns.

### What This Plan Pays

The Plan pays for the following services:

- **Outpatient Care** – Individual or group sessions with a therapist, usually conducted once a week, in the provider's office or facility.
- **Intermediate Care** – Care that is more intensive than traditional outpatient services, but less intensive than 24-hour hospitalization. Some examples are residential treatment, group homes, halfway houses, day/partial hospitals, or structured outpatient programs.
- **In-Home Care** – A licensed mental health professional visits the patient in his or her home.
- **Inpatient Care** – Treatment in a hospital or substance abuse facility.
- **Detoxification** – Medically supervised withdrawal from an addictive chemical substance, which may be done in a substance abuse facility.
- **Drug Testing** – *Precertified* drug testing is covered as an adjunct to substance abuse treatment.

The Plan also covers:

- **Enrollee Assistance Program** – Short-term counseling or other services that focus on problems of daily living, such as marital problems, conflicts at work, legal or financial difficulties, and dependent care needs.
- **www.liveandworkwell.com** – An interactive web site offering a large collection of wellness articles, service databases including a UBH/OptumHealth Behavioral Solutions Massachusetts *network provider* directory, tools, financial calculators and expert chats. To enter the site, log on to [www.liveandworkwell.com](http://www.liveandworkwell.com) and enter access code 10910.

These services are subject to certain Exclusions, which are found in Part III.

## Mental Health, Substance Abuse & EAP Services

### Benefits Chart

The following chart summarizes certain benefits available to you. Be sure to read Part III, which describes your benefits in detail and notes some important restrictions. Remember, in order to receive the maximum benefits, you must *precertify* your care with UBH/OptumHealth Behavioral Solutions before you begin treatment. For assistance, call 24 hours a day, seven days a week: (888) 610-9039 (TDD: (800) 842-9489).

| Covered Services  | Network   | Out of Network  |
|---|---|---|
| Annual <i>Deductible</i>  | None  | \$150 per person (a, b)<br>\$300 per family (a, b)                      |
| <i>Out-of-Pocket Maximum</i>  | \$1,000 per individual (a)<br>\$2,000 per family  | \$3,000 per member (a)<br>No family maximum                             |
| Benefit Maximums  | Unlimited   | Unlimited   |
| <b>Inpatient Care</b>   |   |   |
| <i>Deductible</i>   | \$200 per calendar quarter (a, c)   | \$150 per admission (applies after annual <i>deductible</i> is met) (a) |
| Mental Health<br>General Hospital<br>Psychiatric Hospital<br>Substance Abuse<br>General Hospital or<br>Substance Abuse facility   | Full coverage<br><br>Full coverage  | 80% of <i>allowed charges</i> (d)                                       |
| <i>Intermediate care</i><br>(Care that is more intensive than traditional outpatient services, but less intensive than 24-hour hospitalization. Examples are residential treatment, group homes, halfway houses, day/partial hospitals, or structured outpatient programs.) | Full coverage   | 80% of <i>allowed charges</i> after <i>deductible</i> is met (d)        |
|   | All facility (intermediate and inpatient) care must be precertified. Emergency admissions must be precertified within 24 hours to receive maximum benefits. Non-notification penalty for failure to precertify care is \$200 and your coverage may be reduced for failure to precertify. Non-notification penalty does not count toward out-of-pocket maximums. |   |

Words in italics are defined in Part II.

## Mental Health, Substance Abuse & EAP Services

| Covered Services  | Network Benefits   | Out-of-Network Benefits   |
|---|--|---|
| Outpatient Care (e, f) – Mental Health, Substance Abuse and Enrollee Assistance Program (EAP) |  |   |
| Enrollee Assistance Program (EAP)   | Up to 3 visits: 100%   | No Coverage for EAP   |
|   | EAP <i>non-notification penalty</i> reduces benefit to zero: no benefits paid. |   |
| Individual and family therapy   | 100%, after \$15 per visit   | First 15 visits: 80% of <i>allowed charges</i> (e, f)<br>Visits 16 and over: 50% of <i>allowed charges</i> (e, g) |
| Group therapy   | 100%, after \$10 per visit   | First 15 visits: 80% of <i>allowed charges</i> (e, f)<br>Visits 16 and over: 50% of <i>allowed charges</i> (e, g) |
| Medication Management: (15-30 minute psychiatrist visit)                                      | 100%, after \$10 per visit   | First 15 visits: 80% of <i>allowed charges</i> (e, f)<br>Visits 16 and over: 50% of <i>allowed charges</i> (e, f) |
| In-Home Mental Health Care  | Full coverage  | First 15 visits: 80% of <i>allowed charges</i> (e, f)<br>Visits 16 and over: 50% of <i>allowed charges</i> (e, f) |
| Drug Testing (as an adjunct to Substance Abuse treatment)                                     | Full coverage  | No coverage   |
|   | <i>Non-notification penalty</i> reduces benefit to zero: no benefits paid.     |   |
| Provider Eligibility –<br>Provider must be licensed in one of these disciplines.              | MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS, MA (g)               | MD Psychiatrist, PhD, PsyD, EdD, MSW, MSN, LICSW, RNMSCS, MA (g)  |

(a) Separate from medical *deductible* and medical *out-of-pocket maximum*. *Network* and *out-of-network out-of-pocket maximums* do not *cross accumulate*.

(b) *Cross accumulates* with all *Out-of-network* mental health and substance abuse benefit levels.

(c) Waived if readmitted within 30 days: maximum one *deductible* per calendar quarter.

(d) Out-of-network care that is not preauthorized is subject to financial penalty and retrospective review.

(e) All care requires preauthorization.

(f) All *Out-of-network* visits in a given calendar year are accumulated to determine the appropriate *out-of-network* level of reimbursement.

(g) Massachusetts independently licensed providers: psychiatrists, psychologists, licensed clinical social workers, psychiatric nurse clinical specialists and allied mental health professionals.

Please note: the words in italics have special meanings that are given in the Glossary section.

Words in italics are defined in Part II.



### Part III – Benefits Explained

#### Mental Health and Substance Abuse Benefits

##### Network Services

In order to receive maximum network benefits for EAP, mental health and substance abuse treatment, you must call UBH/OptumHealth Behavioral Solutions at (888) 610-9039 (TDD: (800) 842-9489) to *precertify* care and obtain a referral to a *network provider*.

*Precertified* network care has no *deductible*. Covered services are paid at 100% after the appropriate *copayments* (see *copayment* schedule on page 89). The calendar year *out-of-pocket maximum* for network services is \$1,000 per individual and \$2,000 per family.

The following do not count toward the *out-of-pocket maximum*:

- *Non-notification penalties*
- Cost of treatment subject to exclusions

If you fail to *precertify* your care, you will be charged a *non-notification penalty*. The *non-notification penalty* for each type of service is listed in the Benefit Highlights chart on pages 88–89, and in the following descriptions of services.

##### Network Benefits

**Outpatient Care** – The *copayment* schedule for *network outpatient covered services* is shown below:

- Individual and family therapy, all visits:  
\$15 *copayment*
- Medication Management, all visits:  
\$10 *copayment*
- Group Therapy, all visits:  
\$10 *copayment*
- Enrollee Assistance Program, up to 3 visits:  
No *copayment*

Failure to *precertify* outpatient care results in a benefit reduction to the *out-of-network* level reimbursement, and in some cases, may result in no coverage.

**In-Home Care** – In-home care is a covered service if *precertified*. Treatment that is *not precertified* but deemed to be a covered service receives out-of-network level reimbursement, and in some cases, may result in no coverage. Please refer to the section titled **Out-of-network Services** on page 91 for details.

**Intermediate Care** – *Intermediate care* is covered if *precertified*. This includes, but is not limited to, 24-hour *intermediate care* facilities (for example, residential treatment, group homes, halfway houses, day/partial hospital, and structured outpatient treatment programs). *Intermediate care* that is not pre-certified but deemed to be a covered service receives out-of-network level reimbursement.

**Inpatient Care** – Network inpatient care deemed to be a covered service in a general or psychiatric hospital, or substance abuse facility if *precertified* is covered at 100% after a \$200 per calendar quarter *deductible*. The *deductible* is waived if readmitted within 30 days with a maximum of one *deductible* per calendar quarter. There is a \$200 *non-notification penalty* for failure to *precertify* inpatient care.

**Drug Testing** – *Precertified* drug testing is covered as an adjunct to substance abuse treatment.

**Psychological Testing** – Psychological testing, including neuropsychological testing, that is deemed to be a covered service is covered when *precertified*. Psychological testing that is not *pre-certified*, yet deemed to be a covered service, receives out-of-network level reimbursement if deemed to be a covered service. It is highly recommended that you obtain *precertification* before initiating psychological testing in order to confirm the extent of your coverage. (Guidelines for coverage of psychological testing can be found on the UBH/OptumHealth Behavioral Solutions web site.)

### Enrollee Assistance Program

The **Enrollee Assistance Program** can help with the following types of problems:

- Breakup of a relationship
- Divorce or separation
- Becoming a step-parent
- Helping children adjust to new family members
- Death of a friend or family member
- Communication problems
- Conflicts in relationships at work
- Legal difficulties
- Financial difficulties
- Child or elder-care needs
- Aging
- Traumatic events

To use your EAP benefit, call (888) 610-9039 (TDD: (800) 842-9489). The procedures for *precertifying* EAP care and referral to an EAP provider are the same as for mental health and substance abuse services. You will be referred by a UBH/OptumHealth Behavioral Solutions clinician to a trained EAP provider and/or other specialized resource (e.g., attorneys, family mediators, dependent care services) in your community. The UBH/OptumHealth Behavioral Solutions clinician may recommend mental health and substance abuse services if the problem seems to require more extensive help than EAP services can provide.

### Legal Services

In addition to EAP counseling, legal assistance is available to enrollees of the UniCare State Indemnity Plan/PLUS. The UBH/OptumHealth Behavioral Solutions Legal Assistance services give you free and discounted confidential access to a local attorney, who will answer legal questions, prepare legal documents, and help solve legal issues. The services provide:

- Free referral to a local attorney
- Free 30-minute consultation (phone or in-person) per legal matter
- 25% discount for ongoing services
- Free online legal information, including common forms and will kits

For more information or to be connected with UBH/OptumHealth Behavioral Solutions Legal Assistance, call UBH/OptumHealth Behavioral Solutions toll free at (888) 610-9039 (TDD: (800) 842-9489).

### Employee Assistance Program

The Commonwealth's Group Insurance Commission also offers an Employee Assistance Program to all agencies and municipalities. Managers and supervisors can receive confidential consultations and resource recommendations for dealing with employee problems such as low morale, disruptive workplace behavior, mental illness, and substance abuse.

### Out-of-Network Services

Care from an *out-of-network provider* is paid at a lower level than network care. Out-of-network care is subject to *deductibles*, *copayments*, and *coinsurance*.

Benefits are paid based on *allowed charges* that are UBH/OptumHealth Behavioral Solutions' reasonable and customary fees or negotiated fee maximums. If your *out-of-network provider* or facility charges more than these *allowed charges*, you may be responsible for the difference, in addition to any amount not covered by the benefit.

Out-of-network mental health and substance abuse treatment is subject to a \$150 per person/\$300 per family calendar year *deductible*. Calendar year *deductibles* must be met prior to inpatient *deductibles* and *cross accumulate* between all out-of-network mental health and substance abuse benefit levels.

The *out-of-pocket maximum* for out-of-network care is \$3,000 per person.

## Mental Health, Substance Abuse & EAP Services

The following do not count toward the *out-of-pocket maximum*:

- Out-of-network calendar year *deductibles*
- Out-of-network inpatient *deductibles*
- *Non-notification penalties*
- Cost of treatment found to not be a covered service
- Charges in excess of UBH's/OptumHealth Behavioral Solutions' *allowed charges*

All out-of-network care must be *precertified* with UBH/OptumHealth Behavioral Solutions in order to be eligible for coverage. All *out-of-network* outpatient visits in a calendar year, including mental health, substance abuse and EAP outpatient visits, medication management visits, and in-home mental health care visits, are accumulated to determine the appropriate *out-of-network* level of reimbursement. There are different levels of reimbursement for *out-of-network* outpatient visits 1-15 and visits 16 and over as described below. Charges paid by the covered person for *out-of-network* outpatient care, if determined to be a *covered* service and if *precertified* when required, do count toward the *out-of-pocket maximum*. If it is determined that care was not a covered service, no benefits will be paid.

### Out-of-Network Benefits

**Outpatient Care** – All visits require preauthorization. Preauthorized outpatient visits are paid at 80% of UBH's/OptumHealth Behavioral Solutions' *allowed charges*, up to a maximum of 15 visits per calendar year after your \$150/\$300 annual *deductible* is met. Preauthorized visits 16 and over are paid at 50% of UBH's/OptumHealth Behavioral Solutions' *allowed charges*. Out-of-network care utilized to satisfy the annual *deductible* counts toward the 15 visit maximum. Charges paid by the covered person for outpatient out-of-network care in excess of UBH's/OptumHealth Behavioral Solutions' *allowed charges*, or for sessions after 10 that are not *precertified*, do not count towards the *out-of-pocket maximum*.

**In-Home Care** – Included in outpatient care and require preauthorization. Visits are covered at 80% for the first 15 visits per calendar year after

appropriate annual *deductibles* have been met. Preauthorized visits 16 and over are paid at 50% of UBH's/OptumHealth Behavioral Solutions' *allowed charges*.

**Intermediate Care** – Preauthorized *Intermediate care* is paid at 80% of *allowed charges*, after appropriate annual *deductibles* have been met. All facility (intermediate and inpatient) care must be *precertified*. Emergency admissions must be *precertified* within 24 hours to receive maximum benefits. *Non-notification penalty* for failure to *precertify* care is \$200 and your coverage may be reduced for failure to *precertify*. *Non-notification penalty* does not count toward *out-of-pocket maximums*.

**Inpatient Care** – Preauthorized Out-of-network inpatient care for mental health care or substance abuse treatment is paid at 80% of *allowed charges* in a general hospital, psychiatric facility, or substance abuse facility.

Each admission to a hospital or facility is subject to a \$150 inpatient *deductible* per person in addition to the calendar year *deductible*. All facility (intermediate and inpatient) care must be *precertified*. Emergency admissions must be *precertified* within 24 hours to receive maximum benefits. *Non-notification penalty* for failure to *precertify* care is \$200 and your coverage may be reduced for failure to *precertify*. *Non-notification penalty* does not count toward *out-of-pocket maximums*.

**Drug Testing** – There is no coverage for out-of-network drug testing.

**Psychological Testing** – Psychological testing, including neuropsychological testing, that is deemed to be a covered service is covered when *precertified*. Failure to *precertify* subjects the psychological testing to retrospective review. The UBH/OptumHealth Behavioral Solutions Psychologist determines what aspect of the psychological testing is considered a covered service. No benefits will be paid if it was found not to be a covered service. It is highly recommended that you obtain *precertification* before initiating psychological testing in order to

## Mental Health, Substance Abuse & EAP Services

confirm the extent of your coverage. (Guidelines for coverage of psychological testing can be found on the UBH/OptumHealth Behavioral Solutions web site.)

There is no coverage for *out-of-network* EAP services.

### What's Not Covered – Exclusions

The following exclusions apply regardless of whether the services, supplies, or treatment described in this section are recommended or prescribed by the Covered Person's provider and/or are the only available treatment options for the Covered Person's condition.

This Plan does not cover services, supplies or treatment relating to, arising out of, or given in connection with the following:

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM).
- Prescription drugs or over the counter drugs and treatments. (Refer to your medical plan to determine whether prescription drugs are a covered benefit.)
- Services or supplies for MHSA Treatment that, in the reasonable judgment of UBH/OptumHealth Behavioral Solutions, are any of the following:
  - not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse;
  - not consistent with prevailing national standards of clinical practice for the treatment of such conditions;
  - not consistent with prevailing professional research demonstrating that the service or supplies will have a measurable and beneficial health outcome;
  - typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost-effective; or
  - not consistent with UBH's/OptumHealth Behavioral Solutions' Level of Care Guidelines or best practices as modified from time to time.

UBH/OptumHealth Behavioral Solutions may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.

- Unproven, Investigational or Experimental Services. Services, supplies, or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted stands of medical practice in the United States. The fact that a service, treatment, or device is the only available treatment for a particular condition will not result in it being a Covered Service if the service, treatment, or device is considered to be unproven, investigational, or experimental.
- Custodial Care except for the acute stabilization of the Covered Person and returning the Covered Person back to his or her baseline levels of individual functioning. Care is determined to be custodial when:
  - it provides a protected, controlled environment for the primary purpose of protective detention and/or providing services necessary to assure the Covered Person's competent functioning in activities of daily living; or
  - it is not expected that the care provided or psychiatric treatment alone will reduce the disorder, injury or impairment to the extent necessary for the Covered Person to function outside a structured environment. This applies to Covered Persons for whom there is little expectation of improvement in spite of any and all treatment attempts.
- Covered Persons whose repeated and volitional non-compliance with treatment recommendations result in a situation in which there can be no reasonable expectation of a successful outcome.

## Mental Health, Substance Abuse & EAP Services

- Neuropsychological testing for the diagnosis of attention deficit disorder.
- Examinations or treatment, unless it otherwise qualifies as Behavioral Health Services, when:
  - required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;
  - ordered by a court except as required by law;
  - conducted for purposes of medical research; or
  - required to obtain or maintain a license of any type.
- Herbal medicine, holistic or homeopathic care, including herbal drugs, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Nutritional Counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan.
- Weight reduction or control programs (unless there is a diagnosis of morbid obesity and the program is under medical supervision), special foods, food supplements, liquid diets, diet plans or any related products or supplies.
- Services or treatment rendered by unlicensed providers, including pastoral counselors (except as required by law), or which are outside the scope of the providers' licensure.
- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners.
- Light boxes and other equipment including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
- Private duty nursing services while confined in a facility.
- Surgical procedures including but not limited to sex transformation operations.
- Smoking cessation related services and supplies.
- Travel or transportation expenses unless UBH/ OptumHealth Behavioral Solutions has requested and arranged for Covered Person to be transferred by ambulance from one facility to another.
- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with the same legal residence as the Covered Person.
- Mental health and substance abuse services for which the Covered Person has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
- Charges in excess of any specified Plan limitations.
- Any charges for missed appointments.
- Any charges for record processing except as required by law.
- Services Provided Under Another Plan. Services or treatment for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes but is not limited to coverage required by workers' compensation, no-fault auto, or similar legislation. If coverage under workers' compensation or a similar law is optional for Covered Person because Covered Person could elect it or could have it elected for him or her, benefits will not be paid if coverage would have been available under the workers' compensation or similar law had that coverage been elected.
- Treatment or services received prior to Covered Person being eligible for coverage under the Plan or after the date the Covered Person's coverage under the Plan ends.

Words in *italics* are defined in Part II.



The background of the page features several light blue, wavy, horizontal lines that create a sense of movement and depth. These lines vary in thickness and curvature, some starting from the left edge and others from the right, intersecting and flowing across the page.

# APPENDICES

Appendix A: GIC Notices

Appendix B: Disclosure When Plan Meets Minimum Standards  
(for health insurance coverage in Massachusetts)

Appendix C: Tier Designations for Massachusetts Acute Care Hospitals

Appendix D: Designated Hospitals for Select Complex Inpatient Procedures  
and High-Risk Deliveries and Neonatal ICUs

Appendix E: Claim Form

Appendix F: Bill Checker Form





### Appendix A: GIC Notices

- Notice of Group Insurance Commission Privacy Practices
  - Notice about Your Prescription Drug Coverage and Medicare
  - Important Information from the Group Insurance Commission about Your HIPAA Portability Rights
  - The Uniformed Services Employment and Reemployment Rights Act (USERRA)
- 

#### Notice of Group Insurance Commission Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

By law, the GIC must protect the privacy of your personal health information. The GIC retains this type of information because you receive health benefits from the Group Insurance Commission. Under federal law, your health information (known as “protected health information” or “PHI”) includes what health plan you are enrolled in and the type of health plan coverage you have. This notice explains your rights and our legal duties and privacy practices.

The GIC will abide by the terms of this notice. Should our information practices materially change, the GIC reserves the right to change the terms of this notice, and must abide by the terms of the notice currently in effect. Any new notice provisions will affect all protected health information we already maintain, as well as protected health information that we may receive in the future. We will mail revised notices to the address you have supplied, and will post the updated notice on our website at [www.mass.gov/gic](http://www.mass.gov/gic).

#### Required and Permitted Uses and Disclosures

We use and disclose protected health information (“PHI”) in a number of ways to carry out our responsibilities. The following describes the types of uses and disclosures of PHI that federal law requires or permits the GIC to make without your authorization:

**Payment Activities** – The GIC may use and share PHI for plan payment activities, such as paying administrative fees for health care, paying health care claims, and determining eligibility for health benefits.

**Health Care Operations** – The GIC may use and share PHI to operate its programs that include evaluating the quality of health care services you receive, arranging for legal and auditing services (including fraud and abuse detection); and performing analyses to reduce health care costs and improve plan performance.

**Other Permitted Uses and Disclosures** – The GIC may use and share PHI as follows:

- to resolve complaints or inquiries made on your behalf (such as appeals)
- to verify agency and plan performance (such as audits)
- to communicate with you about your GIC-sponsored benefits (such as your annual benefits statement)
- for judicial and administrative proceedings (such as in response to a court order)
- for research studies that meet all privacy requirements
- to tell you about new or changed benefits and services or health care choices

**Required Disclosures** – The GIC **must** use and share your PHI when requested by you or someone who has the legal right to act for you (your Personal

## Appendix A

Representative); when requested by the United States Department of Health and Human Services to make sure your privacy is being protected, and when otherwise required by law.

**Organizations that Assist Us** – In connection with payment and health care operations, we may share your PHI with our third party “Business Associates” that perform activities on our behalf, for example, our Indemnity Plan administrator. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked of them. These business associates will be contractually bound to safeguard the privacy of your PHI.

Except as described above, the GIC will not use or disclose your PHI without your written authorization. You may give us written authorization to use or disclose your PHI to anyone for any purpose. You may revoke your authorization so long as you do so in writing; however, the GIC will not be able to get back your health information we have already used or shared based on your permission.

### Your Rights

You have the right to:

- Ask to see and get a copy of your PHI that the GIC maintains. You must ask for this in writing. Under certain circumstances, we may deny your request. If the GIC did not create the information you seek, we will refer you to the source (e.g., your health plan administrator). The GIC may charge you to cover certain costs, such as copying and postage.
- Ask the GIC to amend your PHI if you believe that it is wrong or incomplete and the GIC agrees. You must ask for this in writing, along with a reason for your request. If the GIC denies your request to amend your PHI, you may file a written statement of disagreement to be included with your information for any future disclosures.

- Get a listing of those with whom the GIC shares your PHI. You must ask for this in writing. The list will not include health information that was: (1) collected prior to April 14, 2003; (2) given to you or your personal representative; (3) disclosed with your specific permission; (4) disclosed to pay for your health care treatment, payment or operations; or (5) part of a limited data set for research.
- Ask the GIC to restrict certain uses and disclosures of your PHI to carry out payment and health care operations; and disclosures to family members or friends. You must ask for this in writing. Please note that the GIC will consider the request, but we are not required to agree to it and in certain cases, federal law does not permit a restriction.
- Ask the GIC to communicate with you using reasonable alternative means or at an alternative address, if contacting you at the address we have on file for you could endanger you. You must tell us in writing that you are in danger, and where to send communications.
- Receive a separate paper copy of this notice upon request (an electronic version of this notice is on our web site at [www.mass.gov/gic](http://www.mass.gov/gic)).

If you believe that your privacy rights may have been violated, you have the right to file a complaint with the GIC or the federal government. GIC complaints should be directed to: GIC Privacy Officer, P.O. Box 8747, Boston, MA 02114. Filing a complaint or exercising your rights will not affect your GIC benefits. To file a complaint with the federal government, you may contact the United States Secretary of Health and Human Services. To exercise any of the individual rights described in this notice, or if you need help understanding this notice, please call (617) 727-2310, extension 1 or TTY for the deaf and hard of hearing at (617) 227-8583.

# Your Prescription Drug Coverage and Medicare

## Important Notice about Your Prescription Drug Coverage and Medicare

**The Centers for Medicare Services requires that this  
NOTICE OF CREDITABLE COVERAGE be sent to you.  
Please read it carefully and keep it where you can find it.**

Starting January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. This notice:

- applies to you only if you are currently Medicare-eligible or if you should become Medicare-eligible within the coming year;
- provides information about your GIC-sponsored drug coverage and Medicare drug coverage to help you decide whether to enroll in one of the Medicare drug plans;
- explains your options; and
- tells you where to find more information to help you make a decision.

**FOR MOST PEOPLE, THE DRUG COVERAGE YOU CURRENTLY HAVE THROUGH YOUR GIC HEALTH PLAN IS A BETTER VALUE THAN THE MEDICARE DRUG PLANS, SO YOU DO NOT NEED TO PAY FOR ADDITIONAL DRUG COVERAGE.**

## Medicare Drug Plans

The Medicare prescription drug benefit, also known as Medicare Part D, is offered through various health plans and other organizations. All Medicare prescription drug plans provide at least the standard level of coverage set by Medicare; some plans also offer more coverage for a higher monthly premium. In order to decide whether to join a Medicare drug plan, compare which drugs the Medicare drug plans in your area cover and their costs, and consider the following information:

- **You can continue to receive prescription drug coverage through your GIC health plan rather than joining a Medicare drug plan. Most GIC members do not need to do anything and should not enroll in a Medicare drug plan.**
- Your GIC drug coverage is part of your GIC health insurance, which pays for your health expenses as well as your prescription drugs.
- If you elect Medicare drug coverage, you will have to pay for the entire Medicare drug coverage premium.

## Appendix A

- If you should enroll in a Medicare drug plan while you are also enrolled in Fallon Senior Plan or Tufts Health Plan Medicare Preferred (formerly Secure Horizons), you will lose your GIC-sponsored health plan coverage under current Medicare rules.
- If you have limited income and assets, the Social Security Administration offers help paying for Medicare prescription drug coverage. Help is available on-line at [www.socialsecurity.gov](http://www.socialsecurity.gov), or by phone at (800) 772-1213 (TTY: (800) 325-0778).

### Creditable Coverage Information

**Your GIC prescription drug coverage is, on average, expected to pay out at least as much as the standard Medicare drug coverage pays. This means that your GIC coverage is “Creditable Coverage.”** You may need to show this notice to the Social Security Administration as proof that you have Creditable Coverage (to avoid paying a premium penalty), if you later enroll in a Medicare drug plan.

If you drop or lose your GIC coverage and do not enroll in a Medicare prescription drug plan soon after your GIC coverage ends, you could be required to pay a premium penalty for Medicare drug coverage when you do enroll. If your GIC coverage ends and you delay 63 days or longer to enroll in Medicare drug coverage, you will have to pay a premium penalty for as long as you have Medicare drug coverage. Your monthly Medicare drug premium will go up at least 1 percent per month for every month after May 15, 2006 (or the month of your 65th birthday, whichever is later) that you do not have creditable drug coverage. In addition, you may have to wait until the next Medicare annual enrollment period to enroll.

For more information about this notice or your prescription drug coverage options:

- Call (800) MEDICARE – (800) 633-4227. TTY users should call (877) 486-2048.
- Visit [www.medicare.gov](http://www.medicare.gov).
- Call the Group Insurance Commission at (617) 727-2310.

### Important Information from the Group Insurance Commission about Your HIPAA Portability Rights

If you should terminate your GIC health plan coverage, you may need to provide evidence of your prior coverage in order to enroll in another group health plan, to reduce a waiting period in another group health plan, or to get certain types of individual coverage, even if you have health problems. This notice describes certain HIPAA protections available to you under federal law when changing your health insurance coverage. If you have questions about your HIPAA rights, contact the Massachusetts Division of Insurance at (617) 521-7777 or the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272.

#### Using Certificates of Creditable Coverage to Reduce Pre-existing Condition Exclusion Waiting Periods

Some group health plans restrict coverage of individuals with certain medical conditions before they apply. These restrictions, known as “pre-existing condition exclusions,” apply to conditions for which medical advice, diagnosis, care or treatment was recommended or received within six months before the individual’s enrollment date. (An enrollment date is the first day of coverage under the plan, or if there is a waiting period, the first day of a waiting period, usually the first day of work). Under HIPAA, pre-existing condition exclusion periods cannot last longer than 12 months after your enrollment date (18 months if you are a late enrollee). Pre-existing condition exclusion periods cannot apply to pregnancy, or to children who enrolled in health coverage within 30 days after their birth, adoption, or placement for adoption.

If your new plan imposes a pre-existing condition exclusion period, the waiting time before coverage begins must be reduced by the length of time

during which you had prior “creditable” coverage. Most health coverage, including that provided by the GIC, Medicaid, Medicare and individual coverage, is creditable coverage. You may combine any creditable coverage you have, including your GIC coverage shown on this certificate, to reduce the length of a pre-existing condition exclusion period required by a new plan. However, if at any time you had no coverage for 63 or more days, a new plan may not have to count the coverage period you had before the break. (However, if you are on leave under the Family and Medical Leave Act [FMLA] and you drop health coverage during your leave, any days without coverage while on FMLA leave do not count towards a 63-day break in coverage.)

#### When You Have the Right to Specially Enroll in Another Plan

If you lose your group health coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees. In order to do so, however, you must request enrollment within 30 days of your group coverage termination. Marriage, birth, adoption or placement for adoption can also trigger these special enrollment rights. **Therefore, if you have such a life event or your coverage ends, you should request special enrollment in another plan as soon as possible if you are eligible for it.**

#### You Have the Right Not to Be Discriminated Against Based on Health Status

A group health plan may not refuse to enroll you or your dependents based on anything related to your health, nor can the plan charge you or your dependents more for coverage, based on health factors, than the amount it charges similarly situated individuals for the coverage.



## Appendix A

### When You Have the Right to Individual Coverage

If you are eligible for individual coverage, you have a right to buy certain individual health policies without being subject to a pre-existing condition exclusion period. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more.
- Your most recent coverage was under a group health plan (shown on this certificate).

- Your group coverage was not terminated because of fraud or nonpayment of premium.
- You are not eligible for another group health plan, Medicare or Medicaid, and do not have any other health insurance coverage.

**Therefore, if you are interested in obtaining individual coverage and you meet the criteria to be eligible, you should apply for this coverage as soon as possible to avoid forfeiting your eligibility due to a 63-day break.**

### The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The GIC has more generous guidelines for benefit coverage that apply to persons subject to USERRA, as set forth below:

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents while in the military.
- If you don't elect to continue coverage during your military service, you have the right to be reinstated to GIC health coverage when you are reemployed.

- Service members who elect to continue their GIC health coverage are required to pay the employee share for such coverage.
- USERRA coverage runs concurrently with COBRA and other state continuation coverage.
- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at (866) 4-USA-DOL or visit its web site at [www.dol.gov/vets](http://www.dol.gov/vets). If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA. The rights listed here may vary depending on the circumstances.

For more information, please contact the Group Insurance Commission.

### Disclosure When Plan Meets Minimum Standards



*This health plan **meets the Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. Please see additional information below.*

#### MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website ([www.mahealthconnector.org](http://www.mahealthconnector.org)).

This health plan **meets the Minimum Creditable Coverage standards** that became effective July 1, 2008 as part of the Massachusetts Health Care Reform Law. If you are covered under this plan, you will satisfy the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR THE MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2009. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIALS EACH YEAR TO DETERMINE WHETHER YOUR HEALTH PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at [www.mass.gov/doi](http://www.mass.gov/doi).

### Tier Designations for Massachusetts Acute Care Hospitals

As a PLUS member, you can choose from among our list of Massachusetts hospitals, which are designated by their tier (Tier 1, 2 or 3). PLUS members who live in Connecticut, Maine, New Hampshire and Rhode Island have access to additional UniCare network hospitals in their state at the \$500 inpatient hospital deductible. For listings in those states, log onto [www.unicarestatelan.com](http://www.unicarestatelan.com). Under “Find a Provider,” select the link for Out-of-State Network Providers. Or call UniCare Customer Service at (800) 442-9300.

#### PLUS Plan Tier 1 Hospitals

Addison Gilbert Hospital  
Anna Jaques Hospital  
Baystate Mary Lane Hospital  
Baystate Medical Center  
Berkshire Medical Center  
Beverly Hospital  
Brockton Hospital  
Cambridge Health Alliance  
Cape Cod Hospital  
Caritas Carney Hospital  
Caritas Good Samaritan Medical Center  
Caritas Holy Family Hospital  
Caritas Norwood Hospital  
Charlton Memorial Hospital  
Cooley Dickinson Hospital  
Fairview Hospital  
Falmouth Hospital  
Heywood Hospital  
Holyoke Medical Center  
Lawrence Memorial Hospital  
Lowell General Hospital  
Marlborough Hospital  
Melrose-Wakefield Hospital  
Mercy Medical Center  
Merrimack Valley Hospital  
Milford Regional Medical Center  
Milton Hospital  
Morton Hospital and Medical Center  
New England Baptist Hospital  
Noble Hospital  
North Adams Regional Hospital  
Quincy Medical Center  
Saint Vincent Hospital  
Saints Memorial Medical Center  
Somerville Hospital  
St. Luke’s Hospital  
Tobey Hospital  
Whidden Memorial Hospital  
Winchester Hospital  
Wing Memorial Hospital and Medical Centers

#### PLUS Plan Tier 2 Hospitals

Athol Memorial Hospital  
Baystate Franklin Medical Center  
Beth Israel Deaconess Hospital – Needham  
Beth Israel Deaconess Medical Center – Boston  
Children’s Hospital  
Clinton Hospital  
Dana-Farber Cancer Institute  
Emerson Hospital  
HealthAlliance Hospital – Fitchburg  
HealthAlliance Hospital – Leominster  
Hubbard Regional Hospital  
Jordan Hospital  
Lahey Clinic Medical Center  
Lawrence General Hospital  
Massachusetts Eye and Ear Infirmary  
MetroWest Medical Center – Framingham  
MetroWest Medical Center – Natick  
Mount Auburn Hospital  
Nashoba Valley Medical Center  
Newton-Wellesley Hospital  
St. Anne’s Hospital  
UMass Memorial Medical Center

#### PLUS Plan Tier 3 Hospitals

Boston Medical Center  
Brigham & Women’s Hospital  
Caritas St. Elizabeth’s Medical Center  
Faulkner Hospital  
Floating Hospital for Children at  
    Tufts Medical Center  
Harrington Memorial Hospital  
Martha’s Vineyard Hospital  
Massachusetts General Hospital  
Nantucket Cottage Hospital  
North Shore Children’s Hospital  
North Shore Medical Center – Lynn  
North Shore Medical Center – Salem  
South Shore Hospital  
Sturdy Memorial Hospital  
Tufts Medical Center

## Designated Hospitals for Select Complex Inpatient Procedures and High-Risk Deliveries and Neonatal ICUs

There is a \$250 deductible per calendar year quarter for inpatient care at all Massachusetts acute care hospitals designated as Tier 1 in Appendix C of this Handbook. Also, as a PLUS Plan member, you can access the following additional hospitals for certain complex procedures and for high-risk deliveries and neonatal ICU care, at the \$250 deductible level, as indicated in the chart below.

|                                      | Brigham and Women's Hospital | Caritas Saint Elizabeth's Medical Center | Massachusetts General Hospital | Tufts Medical Center | University of Massachusetts Medical Center |
|--------------------------------------|------------------------------|--|--------------------------------|----------------------|--|
| Abdominal Aortic Aneurysm Repair     | ■                            |  |                                | ■                    |  |
| Cardiac Valve Procedures             | ■                            |  |                                |                      |  |
| Coronary Artery Bypass               | ■                            | ■  |                                |                      |  |
| Esophagectomy                        | ■                            |  |                                | ■                    |  |
| High-Risk Deliveries & Neonatal ICUs | ■                            | ■  | ■                              | ■                    | ■  |
| Pancreatic Resection                 | ■                            |  |                                | ■                    | ■  |

The listed procedures have been designated by the Leapfrog Group for Patient Safety<sup>1</sup> as complex procedures that studies indicate are most safely performed at hospitals that meet the following dual-criteria: 1) the facilities have significant experience in performing the procedure and 2) they demonstrate specific clinical practices established by the Leapfrog Group.

Other procedures designated by the Leapfrog Group for Patient Safety as complex procedures are safely performed at multiple Community Choice hospitals; therefore, no additional hospitals are available at the \$250 deductible for these procedures.

<sup>1</sup> The Leapfrog Group is an initiative driven by organizations that buy health care who are working to initiate breakthrough improvements in the safety, quality and affordability of health care for Americans. Leapfrog is a member-supported program aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded. To learn about the Leapfrog Group's patient safety initiatives, visit [www.unicarestateplan.com](http://www.unicarestateplan.com) and click on "Health Care Resources" under the "Members" tab.

## Appendix E



UNICARE LIFE & HEALTH INSURANCE COMPANY  
ANDOVER SERVICE CENTER  
CLAIMS DEPARTMENT  
P.O. BOX 9016  
ANDOVER, MA 01810-0916  
1-800-442-9300



CONTROL 26565 06136 \*

**Medicare Beneficiary**  
After Medicare pays its portion of a claim for medical charges, please complete Section 1, attach the explanation of Medicare payment and/or any bill that indicates the total provider charge, the Medicare allowed charge as well as the Medicare payment, and send to UNICARE.

**Non-Medicare Employees**  
Please complete Sections 1, 2, and 3 in order to receive prompt reimbursement. Section 4 can be completed by your physician or an itemized bill can be submitted in place of Section 4.

### SECTION 1: You must complete this section when filing a claim.

|  |          |   |
|--|----------|---|
| Employee's/Retiree's Name (Please Print) |          | Employee's/Retiree's Soc. Sec. No./ID No. |
| Last                                     | First MI |   |
| Employee's/Retiree's Street Address      |          | City, State and Zip Code                  |
|  |          | Phone No. ( ) ( )                         |

### SECTION 2: If you are a Medicare Beneficiary, please stop here.

|  |   |   |  |   |
|--|---|---|--|---|
| Your Date of Birth:  |   | Male <input type="checkbox"/><br>Female <input type="checkbox"/>  | Marital Status (Check one)<br><input type="checkbox"/> Single <input type="checkbox"/> Divorced<br><input type="checkbox"/> Married <input type="checkbox"/> Legally Separated |   |
| Name of Retiree:   |   | Spouse's Date of Birth:   | Name and Address of Retiree's Employer:  |   |
| Is Claim For Your Spouse/Dependent?  | Name of Dependent, if Other Than Spouse                       | Relationship To You   | Dependent's Date of Birth  | Is Your Dependent Married? <input type="checkbox"/> No <input type="checkbox"/> Yes   |
| <input type="checkbox"/> No <input type="checkbox"/> Yes   |   | <input type="checkbox"/> Child <input type="checkbox"/> Sibling<br><input type="checkbox"/> Other <input type="checkbox"/> Spouse |  | Full-Time Student? <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Employed Full-Time? <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Date of First Treatment For This Kind of Injury:   |   | Name and Address of Doctor (Physician):   |  |   |
| Is This Condition Due to an Injury?  | Is This Condition Due to an Occupational Injury or Disease?   | Date of Injury  | Where Did It Occur?  |   |
| <input type="checkbox"/> No <input type="checkbox"/> Yes   | <input type="checkbox"/> No <input type="checkbox"/> Yes      |   |  |   |
| Describe How Accident Happened:  |   |   |  |   |
|  |   |   |  |   |
| Are You Your Spouse or Your Dependent's Child in Any Other Health Benefit Plan Including Medicare? | If Yes, Name of Member/Subscriber (if different from Patient) | Relationship to Patient   | Other Group/Policy/Contract No.  |   |
| <input type="checkbox"/> No <input type="checkbox"/> Yes   |   |   |  |   |
| Member/Subscriber Soc. Sec. No.  | Name and Address of Other Plan Claims Payment Office:         |   |  |   |
|  |   |   |  |   |

In consideration of benefit payment under this Group Policy, without reduction for any right of recovery under the Workers' Compensation Act, I assign to the UniCare Life & Health Insurance Company my right, title, and interest to any recovery of Workers' Compensation benefits for this disability or injury, however recovered, to the extent of benefits paid under this Group Policy.

I authorize any physician or other medical professional, hospital or other medical care institution, insurer, medical or hospital service or prepaid health plan, employer or group policy holder, contract administrator or plan administrator (not due to UniCare Life & Health Insurance Company in any plan administrator, consumer reporting agency, or attorney acting on UniCare Life & Health Insurance Company's behalf, any medical information and any employment related information regarding the patient. This information will be used only to process and administer claims for benefits.

This authorization is valid for the duration of this claim.

I know I have a right to receive a copy of this authorization and that a photographic copy is as valid as the original.

Any person who knowingly files a statement claiming false, incomplete or misleading information will entitle to an intent to defraud, if it occurs any insurance company is guilty of a crime.

Employee's/Retiree's Signature

Patient Signature, if patient is not employee (Parent, if patient is a minor)

Date

\*UniCare does not insure benefits under control number 06136. Your employer is solely responsible for determination of entitlement to, and payment of, any amounts due under this plan.



## Appendix E

| SECTION 3  |  |  | PATIENT INFORMATION   |  |
|--|--|--|---|--|
| Patient's Name<br>Last First MI  |  | Patient's Sex<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Patient's Relationship to Employer/Relative<br><input type="checkbox"/> Self <input type="checkbox"/> Child<br><input type="checkbox"/> Spouse <input type="checkbox"/> Other           |  |
| Patient's Street Address   |  | Patient's Date of Birth  | Was Condition Related To:<br>Patient's Employment <input type="checkbox"/> Yes <input type="checkbox"/> No<br>An Auto Accident <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| Other Health Insurance Coverage—Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number (including Medicaid/Medicare) |  | Insured's I.D. No. (S.S. No.)  | Insured's Group No. (Or Group Name)   |  |
| Patient's or Authorized Person's Signature<br>(Authorize the Release of any Medical Information Necessary to Process This Claim)<br><br>X                  |  | Insured's Name   |   |  |
| The GIC Indemnity Plan will pay benefits directly to the provider unless a receipted bill is attached.   |  | Insured's Address  |   |  |

| SECTION 4   |                   |  |  |  |   | PHYSICIAN OR SUPPLIER INFORMATION         |  |   |             |
|---|-------------------|--|--|--|---|---|--|---|-------------|
| Date of Illness (First Symptom) or Injury (Accident) or Pregnancy (UMP)   |                   | Date First Consulted You For This Condition  |  | Patient ever had same or similar symptoms?<br><input type="checkbox"/> Yes <input type="checkbox"/> No         |   | Dates of Total Disability<br>From Through |  | Dates of Partial Disability<br>From Through |             |
| Name of Referring Physician   |                   |  |  | For Services Related to Hospitalization Give Hospitalization Dates<br><br>ADMITTED DISCHARGED                  |   |   |  |   |             |
| Name & Address of Facility Where Services Rendered (If other than home or office)   |                   |  |  | Was Laboratory Work Performed Outside Your Office?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  | CHARGES                                     |             |
| Date Patient Able to Return to Work   |                   |  |  |  |   |   |  |   |             |
| Diagnosis or Nature of Illness or Injury. RELATE ICD9 TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE |                   |  |  |  |   |   |  |   |             |
| 1.<br>2.<br>3.<br>4.  |                   |  |  |  |   |   |  |   |             |
| Date of Service   | Place of Service* | Fully Describe Procedures, Medical Services or Supplies Furnished for Each Date Given<br>Procedure Code (CPT4) (Specify Usual Services or Circumstances) |  |  | D<br>Diagnosis Code ICD9                                    | Charges                                   |  |   |             |
|   |                   |  |  |  |   |   |  |   |             |
|   |                   |  |  |  |   |   |  |   |             |
|   |                   |  |  |  |   |   |  |   |             |
|   |                   |  |  |  |   |   |  |   |             |
|   |                   |  |  |  |   |   |  |   |             |
| Signature of Physician or Supplier  |                   |  |  |  | Questions 7, 8 & 9 Must Be Answered Under Authority of Law: |   | Total Charge   | Amount Paid                                 | Balance Due |
| Signed _____ Date _____   |                   |  |  |  | 7. Your Soc. Sec. No.                                       |   | 6. Physician's or Supplier's Name, Address, Zip Code & Telephone No. |   |             |
| Your Patient's Account No.  |                   |  |  |  | 8. Your Employer I.D. No.                                   |   |  |   |             |
|   |                   |  |  |  | 9. Your Employer I.D. No.                                   |   |  |   |             |

\*PLACE OF SERVICE CODES

1- (IH) —INPATIENT HOSPITAL  
2- (OH) —OUTPATIENT HOSPITAL  
3- (DO) —DOCTOR'S OFFICE

4- (PH) —PATIENT'S HOME  
5- (DCF) —DAY CARE FACILITY (PSY)  
6- (NCF) —NIGHT CARE FACILITY (PSY)

7- (NH) —NURSING HOME  
8- (SNF) —SKILLED NURSING FACILITY  
9- (AMB) —AMBULANCE

0- (DL) —OTHER LOCATIONS  
A- (IL) —INDEPENDENT LABORATORY  
B- —OTHER MEDICAL/SURGICAL FACILITY

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6-74

## Appendix F

### Bill Checker Program

The Plan's Bill Checker Program gives you the opportunity to share in any savings resulting from errors you detect on your medical bills. Please note that duplicate claims and services not covered under the Plan will not be reviewed under the Bill Checker Program.

Please attach a photocopy of both the initial and revised bills and mail them to:

**Andover Service Center**  
**P.O. Box 9016**  
**Andover, MA 01810-0916**

---

Enrollee ID #

---

Patient Name

---

Hospital Name

---

Date of Service

Inpatient: ☐ Yes ☐ No

Outpatient: ☐ Yes ☐ No

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UniCare State Indemnity Plan  
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Andover, MA 01810-0916  
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